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ABSTRACT

Five papers cover recent developments in rural mental health nursing. "Rural Mental Health Care: A Survey of the Research" (Karen Babich) chronicles recent interest in understanding the rural population's character and the nature of mental health services needed by and provided to rural America. Lauren Aaronson ("Using Health Beliefs in a Nursing Assessment Model") provides a general model of health behavior to assist people in mastering and performing desired health behaviors. Jeri Bigbee and others present a nursing needs assessment tool in "Interviewing the Rural Community to Determine Nursing Needs." "Viewing Health and Health Needs through Many Eyes: The Ethnographic Approach" (Jacqueline Taylor) reports that a five-year survey of health care needs is revealing interesting and sometimes unexpected information about how rural Montanans view their own health and medical treatment. Judson Morris and Lynne Morris discuss difficulties involved in "Training Human Service Workers for Practice in Boom Towns and Other Changing Rural Communities" and include a nets and links simulation game. "Being There: A Nursing Program that Introduces Students to the Practical Problems and Rewards of Outpatient Rural Mental Health Care Delivery" (Illa Hilliard and others) describes how one baccalaureate nursing program responded to the mental health needs of rural eastern Washington. (BRR)

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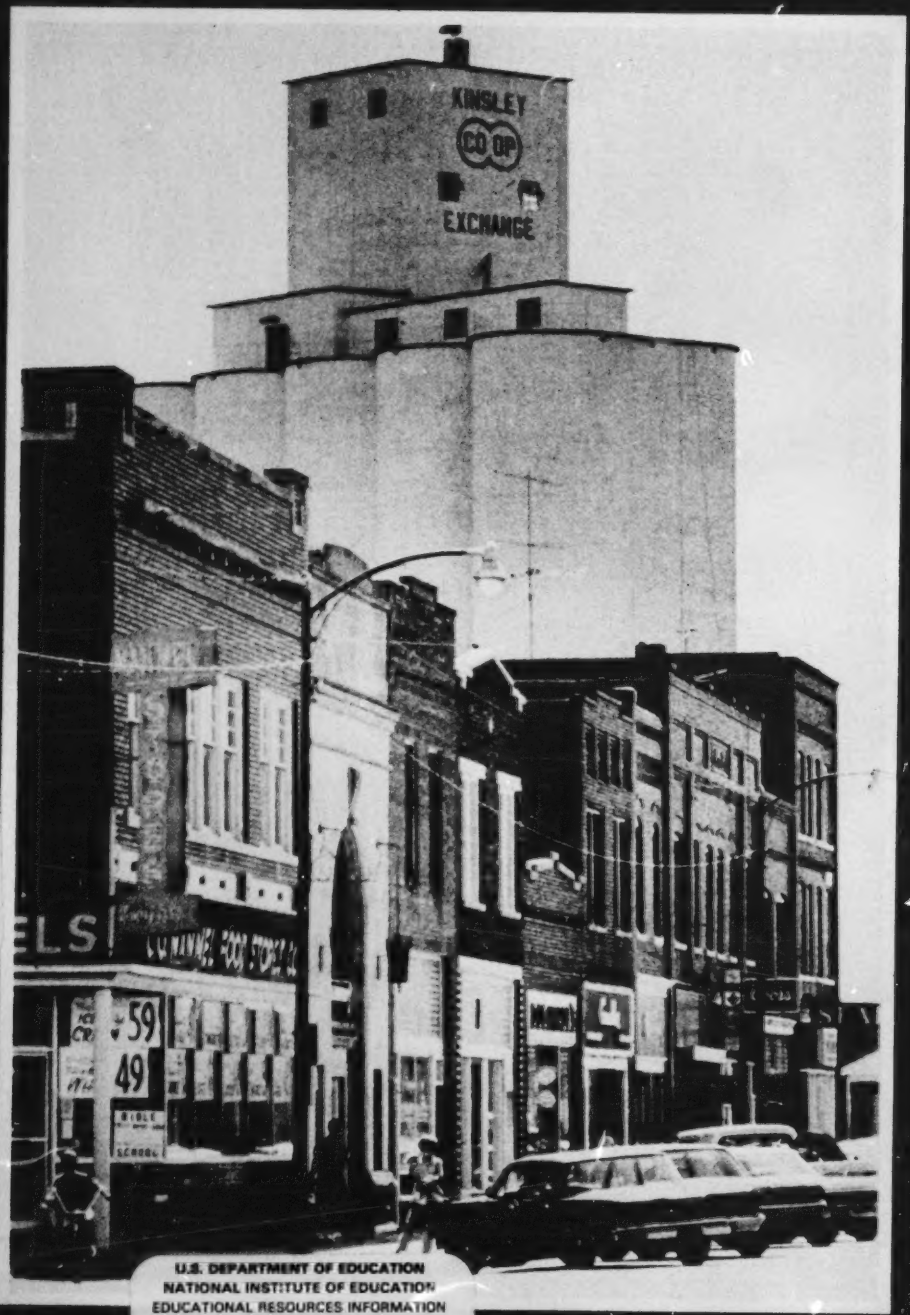

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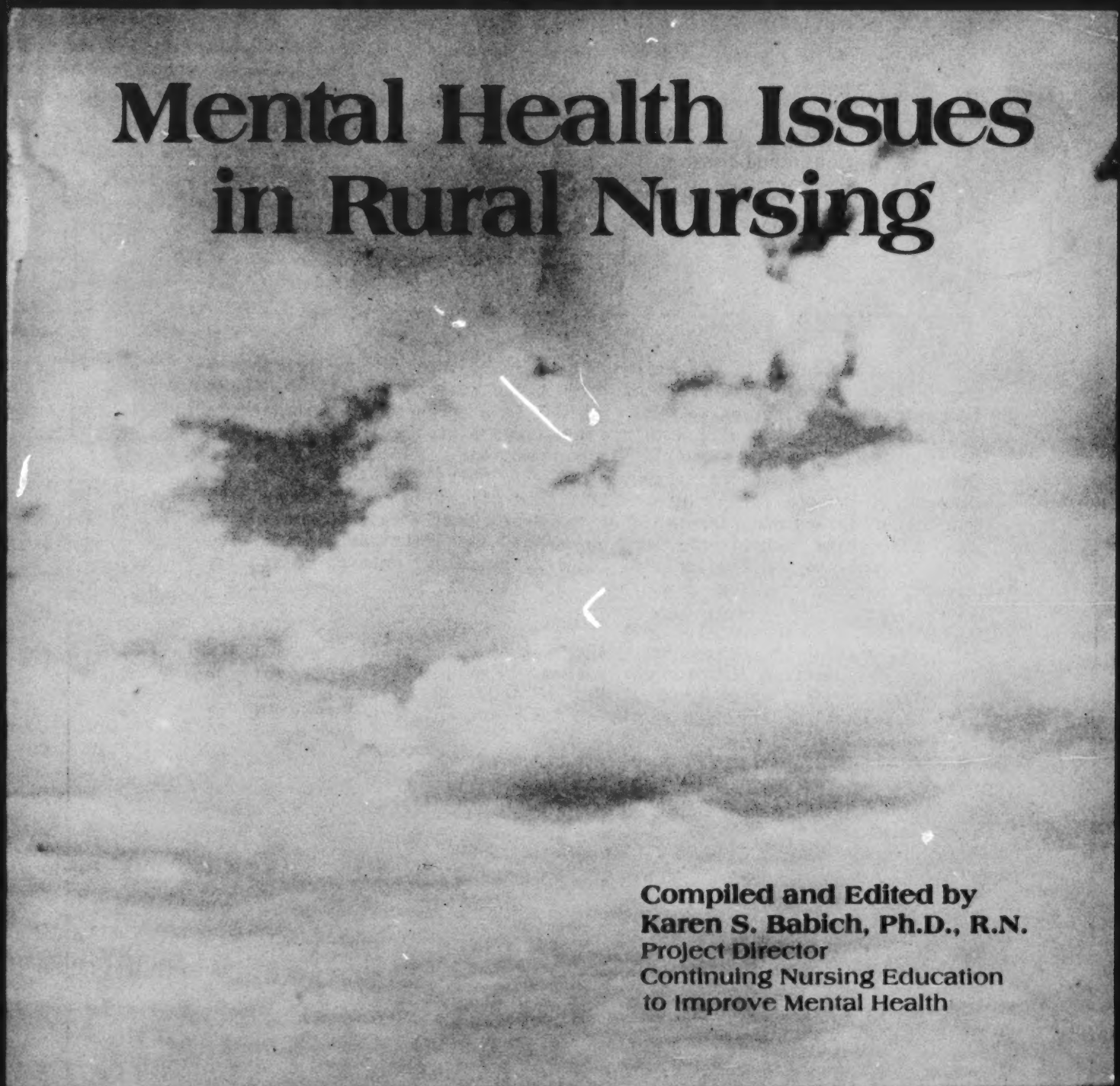

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to Improve Mental Health

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FOREWORD

"Winds of change" seems to describe best the recent developments in rural mental health nursing. Not too many years ago, rural nursing appeared simple compared to the multifaceted problems confronting rural nurses today. Rapid technological changes, advances in knowledge and its transfer methodology, and differing life styles of individuals and families have intensified the complexity of rural nursing in toto. Despite the relatively new focus on mental health issues in rural areas, however, mental health services remain a stepchild in the overall rural health scene.

History (the chart and compass of national endeavor) clearly shows that rural areas have never received their fair share of financial aid and input of human resources when compared with nonrural areas. A few years ago, the staff of the Western Interstate Commission for Higher Education (WICHE) realized that many nurses in the West, including those serving vast, thinly populated rural areas, were having difficulty gaining access to up-to-date professional information. Hoping that exposure to the latest research would help counter this professional isolation, they submitted a continuing education grant application to the Psychiatric Nursing Education Branch, National Institute of Mental Health, requesting and ultimately receiving federal funds to conduct regional continuing-education workshops predicated upon research-based findings and to publish monographs based on these programs.

A literature review of past research on psychiatric/mental health nursing issues comprised the first phase of the project, with the second phase focusing on workshops and publications. The literature survey emphasized three important and also topical areas: 1) the epidemiological view of the evidence of psychiatric problems and the more recent labeling of some rural behaviors as social problems; 2) the shortage of mental health personnel and the use of public health and general hospital nurses as community counselors; and 3) the identification of factors that seemed to provide success in the instituting of mental health programs and the recruitment and retention of staff.

One of the identifiable successes of this continuing education project is the publication of this monograph on rural nursing. It provides a vehicle for nurse researchers and other investigators to share their research interests and identifies many usable findings of current research on mental health issues in rural America, particularly the rural West, that have not previously been accessible to the nursing profession.

As you read this monograph, you will understand as I did the potential effects Mental Health Issues in Rural Nursing can have for nursing education and clinical practice in highly complex and often underserved rural settings from traditional farming communities to modern boom towns.

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Special thanks and recognition are given to nurse educators and rural nurses working in mental health facilities and to community health agencies and general hospitals who have shared in identifying strengths and weaknesses of rural mental health care delivery and who have devised methods for addressing these issues. As generalists, they practice what urban specialists wish for -- treating the whole being in the community context.

I would also like to extend my heartfelt thanks to the unbeatable monograph team of Margaret Timothy and Lucy Warner. Their wit, wisdom, and caring are reflected in the pages of the monograph.

Karen Babich, Ph.D., R.N.
Editor

RURAL MENTAL HEALTH CARE:

A SURVEY OF THE RESEARCH

by

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During the course of history, rural America has been rediscovered many times. In mental health circles, its most recent discovery was in the 1970s. That decade marked a renewed interest in understanding the character of the rural population and the nature of the mental health services needed by and provided to rural Americans. The rediscovery was perhaps spurred by the fact that for the first time in decades non-metropolitan areas, rather than losing population, experienced a higher growth rate than metropolitan areas. In fact, towns located some distance from metropolitan areas grew faster than the nation as a whole (U.S. Bureau of the Census, 1980). According to Price and Clay (1980), this shift in the balance of net migration toward nonmetropolitan growth was a reflection of the increased demand for energy resources and food supplies, the relocation of retail and service industries to rural small towns and cities, and an increase in retired people, as well as others, seeking the life style and lower cost of living associated with rural living.

A second factor leading to renewed interest in rural mental health was the introduction of federally funded community mental health centers in sparsely populated areas across the country. Not only did the community mental health movement bring about increased awareness of psychiatric problems in rural areas, it also created a new perspective on some behaviors not previously labeled as problems, such as "seasonal alcoholism" among farmers when not actively planting or harvesting, problems viewed by many rural residents simply as ways of life.

A third factor was the desire to focus on an "ideal life," a romanticized vision of the rural setting probably influenced by the frustration and burn-out of dealing with the urban social problems of the 60s. The lessons learned from studying the social problems of the 60s were not lost on rural research. For example, researchers were less likely to view poverty (which is often synonymous with rural life) as resulting from attitudes maintained by the poor (i.e., the culture of poverty) and came to recognize that "the values and attitudes of the poor represented adaptation to a set of social and economic conditions, and that movement out of poverty depended on changes in social structure rather than on individual attitudes" (Segal, 1973, p. 55). That is, social problems were perceived as the product of complex interrelationships involving the individual, the cultural environment, and the structure and institutions of society. The individual, while a contributing actor, was not the sole source of his/her problems.

In her overview of the problems encountered in delivering health care services to rural areas, Bachrach (1981, pp. 11-12) has succinctly stated the eight most commonly cited issues.

Although every community is unique, with its own problems, its own patterns of caring for those in need, and its own special resources, there is substantial evidence in the literature that a common set of problems generally characterizes the delivery of human services in rural portions of the nation. While specific communities may not fit the general picture in all particulars, there is consensus that human services in rural communities tend to be affected by the following kinds of interrelated circumstances:

1. Demographic trends of the past several decades have skewed rural populations so that they are frequently characterized by excesses in the dependent age groups. Because many young and/or fit individuals migrate out of rural communities, there is a residue of elderly and/or impaired individuals remaining in them. Many rural communities are thus characterized by disproportionate numbers of persons who require help in the conduct of their everyday lives and assistance in gaining access to entitlements.

2. The recent influx of nonindigenous populations and economic interests (suburbanization and industrialization of rural communities) has complicated the demography of rural America. In some places, inmigration has produced social upheavals and/or environmental problems that the involved communities are ill equipped to confront. These massive social changes have disrupted existing organic helping patterns and, in many instances, have created new and unusual human service needs.

3. Rural populations frequently have great difficulty gaining access to resources and entitlements. A variety of barriers to service delivery -- physical, social, economic, and attitudinal -- confound the utilization of service facilities. In any given rural community, it is difficult to isolate, and thus to correct, human service deficits produced by any single variable: service requirements and the conditions that produce and exacerbate them form a gestalt that is difficult to penetrate with service interventions.

4. There is an overlay of poverty in many rural areas that complicates the problems of those residents who are already highly dependent by virtue of their demographic characteristics, disabilities, and functional levels. In addition, the sparseness of population in these communities serves to limit the number and array of human services that are economically feasible; the per capita costs of providing special services to few people are often prohibitive.

5. Transportation difficulties produce major barriers to service delivery in rural places, and these, in turn, are affected by the prevailing climatic, geographic, demographic, and economic conditions in rural areas. Geography has been identified as the common denominator of service deficits in rural communities, whatever their specific character.

6. Residents of rural communities who experience human service needs are frequently unable to advocate on their own behalf. They tend to be limited by their own disabilities and often lack the sophistication and know-how associated with gaining access to care. Moreover, political power in rural places is often vested in an elite portion of the population that is not attuned to the needs of the underprivileged. In many rural communities, powerless racial and ethnic minorities experience human service requirements to which the more affluent and powerful majority population are unsympathetic and of which they are often not even aware. Access to federal and other governmental and nongovernmental funding sources is hampered both by what has been described as a general absence of "grantsmanship" and by political structures that resist outside help.

7. There is an inequitable distribution of human service delivery personnel in rural areas. Most human service workers are urban trained and urban oriented and are employed in urban settings. Even those who choose to work in rural communities may soon become "burned out" by the unremitting demands of their jobs. They lack anonymity, they are often required to serve as "generalists" and effectively forget their specialty training, their compensation is frequently not commensurate with their training, and they may experience hostility as "outsiders" in tightly knit communities. As a result, staff recruitment and retention tend to be major problems in rural human service programs.

8. Since the majority of Americans live in metropolitan areas and a majority of human service planners have urban backgrounds, there is a general lack of awareness at policy-making levels of the uniqueness of rural human service needs. For example, "mainstreaming" physically or mentally handicapped children tends to be difficult enough even for urban communities to achieve, but it may well be impossible in rural places where the target population is numerically small and thinly spread. Similarly, "meals on wheels" and other such services for senior citizens and other dependent persons are difficult to organize in many rural communities where weather conditions and poor roads complicate the delivery of outreach services. Again, problems of spouse and child abuse may go untreated in rural places where attitudes and a paucity of service structures inhibit the provision of help in combating such conditions. And day care for working mothers may similarly be exceedingly difficult to organize.

As Bachrach notes, these issues are complex and interrelated. However, they seem to be addressed in three broad categories of studies. The first category is research done for the purpose of

identifying and determining the nature and characteristics of the rural consumer population. These studies have become the basis for identifying problems and establishing the need for intervention by mental health professionals. They encompass items one, two, and six on the preceding list. The second major category of studies is those conducted on characteristics of providers. By studying the profiles of mental health professionals who stay in rural areas, this research attempts to predict which students will be successful in rural work and to identify the knowledge and skills needed for rural mental health practice so that they can be incorporated into curriculum planning. The goal, as stated in item seven, is to address and resolve the maldistribution of mental health personnel. The last category is research studies that focus on utilization of services. Generally, these studies identify the difficulties in providing services to the populations identified as having the greatest need (see items three, four, five, and eight on the preceding list). This category also includes narrative descriptions of programs that seem to work because they address both the needs and norms of the community.

Before discussing the findings of the studies conducted in each of these categories, a few general comments should be made about problems encountered in conducting and interpreting rural research. In the literature reviewed, authors agree almost unanimously that it is difficult to define rural, that what is considered rural is relative to one's own reference point. To avoid controversy and attempts to "outrural" one another, most authors accept (with reservation) federal agencies' definitions. The U.S. Bureau of the Census (1980) defines rural as an area in which 50 percent or more of the population lives in

communities of 2,500 or less. The Bureau of the Budget uses a metropolitan/nonmetropolitan classification scheme. In this scheme, Standard Metropolitan Statistical Areas (S.M.S.A.s) consist of a county or a group of contiguous counties containing at least one city of 50,000 inhabitants or more, or "twin cities" with a combined population of 50,000 or more. In addition, contiguous counties are included in an S.M.S.A. if they meet certain criteria pertaining to their social and economic integration with the central city. For New England states, cities and towns are the units used to define S.M.S.A.s rather than counties (U.S. Bureau of the Census, 1978). In 1980, an estimated 63 million people lived in nonmetropolitan areas, a number that represents 28 percent of the nation's population (Beale, 1981).

Much of the research done has focused on particular rural groups (e.g., whites in Appalachia) or on rural populations in a handful of states (e.g., North Carolina, Tennessee, Maryland, Colorado, and Montana). Because of the unique history, geography, religious and ethnic diversity, economic base, and socioeconomic divisions of each of these populations, it is difficult to generalize the findings to other rural populations or to consider rural society as a homogeneous population (Hassinger, 1976).

Flax et al. (1979), authors of the N.I.M.H. publication Mental Health and Rural America: An Overview and Annotated Bibliography, advise the reader to be aware that statements about the prevalence of mental disorders in rural areas and rural-urban mental health comparisons, like most statements on psychiatric epidemiology, should be made cautiously. They cite research design and methodological problems

such as sampling, measurement of cases, source of data, and differences in types of instruments that may invalidate meaningful comparisons between groups. Attention has also been drawn to the bias inherent in using standards drawn from urban mental health care models to measure utilization of rural services (Bachrach, 1977). The urban bias is also present in client and community needs assessment techniques and in client and program evaluation protocols (Berger, 1980; Zody, 1980).

Despite these difficulties, a rural mental health model is emerging that is distinct from the urban model. It has been shaped by the experiences and research of those working in rural areas. As with other social research, the "mainstream" learns a good deal about the implicit assumptions on which it bases mental health care by studying groups whose characteristics and need for services deviate from the usual.

CHARACTERISTICS OF THE RURAL CLIENT

Values

In general terms, values refer to culturally held definitions of reality and serve as anchor points in helping us view human relationships and appropriate behavior in varying circumstances (Wagenfeld, 1981). It was noted earlier that there is no such thing as a culture common to all rural residents. However, there is general agreement that living in small towns or sparsely populated areas creates experiences that contrast with urban life and might be considered a rural way of life (Dunbar, 1982a).

The themes most often cited as reflecting rural values include subjugation to nature, fatalism, an orientation to concrete places and things, a view of human nature as basically evil, and an emphasis on primary relationships and family ties (Flax et al., 1979; Task Panel on Rural Mental Health, 1978). As Rogers and Burdge (1972) note, the values of individualism, traditionalism, familism, fatalism, and person-centered relationships found in Ozark and Appalachian whites and in Southern rural blacks are values also held by the poor in Third World nations. This, of course, reflects the interactional nature of values and suggests that they are derived as much from the sociopolitical environment as they are from epistemologies learned in family settings.

Hassinger (1976), in his review of a number of studies comparing rural and urban value differences, concludes that the two populations do differ slightly in value sets held. He notes that rural people tend to be more conservative, religious, oriented to the Protestant work ethic, intolerant of nontraditional beliefs, authoritarian, ethnocentric, and family centered. Rural life is characterized by spatial isolation, by an agricultural orientation (an orientation to seasons and the land), and by community and social organizations that focus on informal face-to-face negotiations with the town being the center of trade and the church and schools being the center of social activity.

Such values influence both what is considered mental illness and mental health and the treatment sought. In addition, difference in cultural norms affect labeling of behavior as pathological and have bearing on the significance of epidemiological studies contrasting the

mental health of rural residents with that of urban residents. Some forty years ago, sociologist Kingsley Davis (1938) pointed out that the mental health movement was largely a purveyor of white, middle-class values disguised as mental health or medical values. He went on to state that psychiatry could become a scientific rationalization for making moral judgments about the whole social system and especially those who deviate from the urban mainstream. Used appropriately, however, epidemiological studies can provide important data for developing and evaluating mental health delivery systems.

Epidemiological Studies

In trying to ascertain the prevalence of psychiatric problems in rural areas, researchers have approached the problem by measuring the "treated prevalence" (those who have actually used the health system for mental problems) or by trying to extrapolate "true prevalence" from survey findings that focus on determining the mental health of the population.

Perhaps the most quoted of the treated prevalence studies is the work done by Mazer (1976). He used data from a town's community mental health center and physicians to describe the incidence of emotional problems among the full-time residents of Martha's Vineyard, a rural summer resort on an island off the coast of Massachusetts. Using three separate sources for collecting data, he arrived at three different rates of prevalence. In one survey he contacted general practitioners on the island and found that 8 percent of their caseloads consisted of persons who had diagnoses of psychoneurosis, psychophysiological disorders, and personality disorders. Of this group alcoholism ranked

highest as the presenting problem for males, and anxiety, depression, and hypochondriacal reactions constituted the highest percentage of cases labeled psychoneurotic reactions. Based on these data, he concluded that one out of every twenty persons contacted a general practitioner for a psychiatric condition.

Prevalence rates for those treated at the community mental health center totaled approximately 2 percent of the community's population. Personality disorders, psychoneuroses, alcoholism, and psychoses were the major diagnostic categories treated.

In a third survey he reviewed the community registry and listed the prevalence of stress events or what he termed "parapsychiatric events." He reasoned that such events as going to jail, having a driver's license suspended, school disciplinary problems, juvenile delinquency charges, and divorce and separation are really psychiatric disorders but are not labeled as such by nonpsychiatric agencies. Twenty-two percent of the population had experienced stresses that fit into this category.

Using three different definitions of psychiatric disorders, Mazer's prevalence rates varied from 2 to 22 percent of the population as requiring psychiatric help.

In a recent study conducted in Colorado, Grosser and Winfrey (1981) examined admission rates in community mental health centers and state hospitals to determine the utilization rate for rural and urban counties. One of their most interesting conclusions is that "In certain ways the most rural areas may have more attributes in common

with the most urbanized portions of the state than with suburban and midsize communities" (p. 21). Their data showed the highest utilization rates in northwest Denver, followed by rural areas. Unlike what has been found in other studies (Dohrenwend and Dohrenwend, 1971), the highest rates of admission for psychotic disorders were from the urban area; this trend was also true for alcohol abuse. Northwest Denver is comprised of the downtown area, skid row, and some highly impoverished residential neighborhoods. This catchment area has high rates of suicide and unemployment and seems to attract transients and the chronically mentally ill. This raises the question of the relationship between mental illness (or the labeling of mental illness) and socioeconomic and political factors that have influence on the functioning of residents of very rural and very urban areas.

Dohrenwend and Dohrenwend (1971) analyzed nine urban/rural prevalence rate studies. In one study the rate of mental illness was higher for rural residents, in one there was no difference, and in the other seven urban areas had the highest rate of mental illness. In examining the data more closely, they suggest that the higher urban rate is an artifact of combining neurosis and personality disorder diagnoses, which are more common than psychoses. If the comparisons are made according to diagnosis, rural areas have more admissions for psychoses, whereas urban areas have higher incidences of neurosis and personality disorders.

Derr (1973) notes, however, that the Selective Service rejection rate for psychosis among urban recruits was 3.1 per 1,000 as compared to 4.5 per 1,000 among rural recruits and that this same trend appeared

for rejection rates because of neurosis (37 and 44 per 1,000 for urban and rural youth respectively).

In attempting to determine the true prevalence of mental illness in urban and rural areas, a number of studies have assumed that disordered behavior is reflective of stress. The most commonly used instrument for measuring stress is the twenty-item Health Opinion Survey (H.O.S.) developed by Leighton and others (1963). Basically the symptomatology measured by the H.O.S. is psychoneurotic and psychophysiologic. The H.O.S. has concurrent validity with D.S.M. diagnoses.

Using the H.S.O. to measure rural residents in Nova Scotia, Edgerton et al. (1970) found that three-fourths of the population could be considered well, 14 percent were "probable" psychiatric cases, and 10 percent were definite cases. The target, or high-risk, group consisted of blacks, the elderly, single or divorced people, and low S.E.S. groups. There was also a slightly higher incidence for rural areas than for small towns. Similar findings on the inverse relationship between population and size of area and psychiatric disorder are also reported by Schwab, Warheit, and Holzer (1972) and Srole (1977). In their study of an area of Florida undergoing rapid change, Schwab et al. also noted an interesting inverse relationship between the size of the town of origin and the probability of needing psychiatric help. In their survey, persons from rural populations of less than 2,500 were five times more likely to have high stress scores than residents of towns over 500,000. Although the sample sizes used for comparisons are small, their analysis also suggests that those with rural roots seem to fare

more poorly on the H.O.S. regardless of whether or not they have moved to an urban area.

While these findings are interesting, their significance to program planning is not clear. As Flax et al. (1979) point out, the H.O.S. and other such instruments tend to be highly reliable in measuring traits similar to traditional psychiatric categories; however, it still is not clear exactly what is being measured. Stated another way, it may be that the measures of mental health derive their norms from urban populations and that rural residents, especially the poor, elderly, and ethnically diverse, who hold rural value sets, will always appear deviant on these measures.

CHARACTERISTICS OF THE RURAL MENTAL HEALTH PROVIDER

Traits and Tasks of the Provider

Recruiting and retaining mental health personnel in rural areas have always been difficult problems. The person choosing to work in the rural setting must confront issues that his or her urban counterpart can easily avoid or does not face. It is not overstating the case to say that the rural mental health professional must be a generalist in working with all age groups on a myriad of presenting problems while at the same time being a specialist in community organization and development. In addition to being a treatment generalist and a community-organization specialist, the rural professional must deal with high visibility in the community and know that his or her professional competence must be proven through the personal and professional roles performed every day.

In discussing the steps required in making a transition from urban to rural practice, Bischoff (1976) outlines four tasks confronting the therapist. These include: 1) conducting a formal community assessment on how policy is made and by whom and also noting subjective views of the ambiance of the community; 2) self-assessment -- viewing one's ability to be versatile, adaptable, sensitive, and willing to be involved in the community; 3) dealing with the paradox between one's own lack of privacy in the community and the need to maintain confidentiality of client information; and 4) understanding the distinctions between professional and personal relationships, issues inherent in treating "friends" and working with other professionals.

A number of books and articles are available that provide anecdotal accounts of the joys and pains of becoming acculturated to the rural community (Mazer, 1970; Pentlarge, 1975; Riggs and Kugel, 1976; Crow, 1971). These accounts are valuable sources of information regarding the processes and issues confronted by mental health professionals. A systematic review of the similarities and differences between urban and rural practice based on these accounts might shed some light on the stages of acculturation and provide useful information in designing curriculum and orienting new personnel to rural mental health settings.

Profiles of rural mental health workers -- their attitudes, work conditions, and living situations -- are also valuable sources of information in determining program needs for retaining rural professions. In reporting their findings on the characteristics of the work place and workers in mental health settings in Washington, Oregon, Idaho, and

Alaska (N = 127), Dunbar, McKelvy, and Armstrong (1980) note that rural practitioners planned to remain in the rural setting despite the usual problems of being fairly isolated and without many referral sources, and serving as a generalist conducting a range of activities from administration to therapy to community development. Their data show that the decision to stay or leave is usually made in the first year of work in a rural setting and that those who want to leave do so within a three-year period.

In examining the characteristics of mental health professionals who chose rural practice, they found that:

- the largest group of those planning to remain in the rural area (81 percent) had grown up in towns with populations under 30,000. Definition of oneself as a rural person was significantly related to intent to remain in the rural area;
- people who had a spouse or significant other living with them indicated that they planned to stay in rural areas more often than those who did not have a partner. Having children did not seem to be a factor.

Two-thirds of the respondents in this study lived and worked in towns of less than 10,000, and over half worked with a total staff of three people. In commenting on the problems encountered, the authors note (p 11), "The lack of appropriate resources for referrals and professional isolation are the major sources of stress in working in rural areas. Narrowness of community attitudes and ideas was cited by 11 percent of the respondents, and 18 percent mentioned the stress created because of lack of privacy."

When asked how adequately their professional education prepared them for what they were doing, over half felt that they had been

adequately prepared. Suggested areas for further education ranged from more training in psychoanalytic theory and practice (24 percent) to more training in grants, funding, and management (1 percent).

Based on this preliminary data, the authors have identified the following needs (p. 19):

> 1) the development of continuing educational opportunities; 2) mutual support and communication networks among practitioners; 3) generalist education; 4) practicums and internships in rural communities; 5) selection of people for rural practice who have life experience in rural areas and a commitment to "ruralness"; and 6) selection of practitioners who appreciate isolation and the environmental advantages of less populated areas and who enjoy outdoor recreation and participatory sports.

Although the majority of respondents in the study cited above were psychologists (45 percent) and social workers (29 percent), the same issues -- professional isolation and lack of educational mechanisms to update knowledge, and the sense of being "on call" twenty-four hours a day to respond to a wide range of clients' and neighbors' physical and emotional needs -- are listed as problems confronting the rural nurse as well (Fletcher, 1981). The Fletcher study showed that rural nurses were also very interested in having more information on what factors would help to recruit the type of nurse who would be satisfied with living and working in a rural area.

In trying to address this question, the University of Northern Colorado School of Nursing has been collecting data on students' employment sites after graduation and studying factors that influence their decision to work in a rural area. From the preliminary data, it appears that two-thirds of the students who chose to work in a rural area were not from a rural area. However, 83 percent of these students

had spent a three-month nursing preceptorship in a rural community with a population under 13,000 (Christensen, Drennan, and Kerns, 1981). Thus, both exposure to rural areas and the confidence that they had the knowledge and skills to be generalists seemed to be key factors in nurses' decisions to practice in rural areas.

Curriculum

Hargrove and Howe (1981), in discussing their rural mental health training program for psychologists, note that the basic assumption underlying their curriculum is the belief that the psychologist will seek and stay in a job that s/he has been best trained for and feels comfortable with. Hence, if the curriculum can anticipate the skills required in rural mental health delivery and provide these on both a theoretical and experiential basis, more psychologists will locate in rural areas.

In discussing the characteristics of rural mental health practice, they note that psychologists, as well as nurses, psychiatrists, and social workers, are both generalists within their particular disciplines and mental health generalists. At the present time, however, most of their training occurs in urban settings where the major focus is on acquiring skills and tends to isolate them from the interactive role between the agency and the community -- an extremely important component of the rural mental health professional role.

Dunbar (1982b, p. 9), in discussing the generalist curriculum, states: "The ability to assess community dynamics, culture, structure, politics, and resources is one basic requirement for preparation for

rural practice." She goes on to point out that the generalist must see the individual within the context of the total environment and the social factors that impinge upon that individual's life. "This involves more than understanding their internal realities and responses to the immediate environment. It includes the knowledge of how the social system shapes that inner reality" (p. 16). The generalist curriculum, then, should have the following components:

- It begins with the social context and moves to the individual within that context, seeing the individual within the context of the full environment and the social factors impinging upon that individual.
- It teaches a general method of intervention for all situations and age groups rather than specialized therapies for specialized groups. Exposure to specific therapeutic methods is provided but is not the major focus.
- It helps students to compartmentalize roles rather than relationships in working with people in small towns who may be neighbors as well as clients.
- It views all presenting problems as potentially needing therapeutic intervention at any level (i.e., individual, group, organization, family, community, society) and helps students develop familiarity with a wide range of presenting problems and the human service system that addresses them.
- It introduces basic skills in administration, supervision, planning, and politics.

CHARACTERISTICS OF RURAL MENTAL HEALTH PROGRAMS

The profiles of professionals and needs of consumers as identified by rural research often influence the design of rural mental health programs, and ideally the three issues are closely related. Research on rural mental health programs consists largely of descriptive reports on specific mental health centers and generally reflects the adapting and molding of a program to fit the needs of particular groups, such as

programs for Vietnam veterans in Appalachia (Giles, 1981) or the chronically mentally ill in Vermont (Huessy, 1981). The case history approach does have the advantage of reporting what occurred at each stage of development and provides the reader with concrete information on programs and approaches to use. However, case histories do not lend themselves to meaningful comparisons with other agencies. Such comparisons would be helpful in identifying and planning resources required for rural mental health centers.

For example, it would be important to know what services a rural psychiatric nurse provides and how her particular skills and knowledge might best be utilized. In the literature there are descriptions of the kinds of activities and services provided by psychiatric nurses in rural emergency care settings (Marshall, 1971; Carter, 1973), in rural day-care treatment programs (Janzen, 1974), and in liaison roles with other agencies such as nursing homes and public health agencies (Duran, 1970). In an effort to better understand how the psychiatric nursing role was perceived by the staff and nurses at rural mental health centers, Forrest (1973) designed a study to examine the leadership behavior of community psychiatric/mental health nurses in the rural Midwest. Her findings indicate that psychiatric nurses perceive themselves and are perceived by others as assuming leadership in all areas of work in which the centers are engaged. Nurses' leadership ranked highest in providing consultation on patient care to nursing homes, hospitals, and public health agencies and in providing educational programs to nursing personnel in these agencies. Nurses were seen by other staff to deal mainly with symptoms rather than with underlying dynamics when doing therapy, to be ineffective in using colleague

consultation, and to have difficulty relating to psychiatrists and psychologists as peers.

It would be most interesting to replicate the study to see if there are geographic variations as well as differences over time. The findings would be most useful in program planning. For instance, if the consultative and educative roles of the mental health center are best served by psychiatric nurses who have a natural network with hospital, nursing home, and public health nurses, then nurses would be excellent designers and developers of new programs that require community support and programs that focus on prevention of mental illness.

From a different perspective, it would be interesting to study more closely the psychiatric nurses' relationships with colleagues. If the finding is true that the nurse is perceived as being different (not a peer and less effective at using consultation than others), then does s/he experience more professional isolation than others in rural settings? How many nurses are employed in rural mental health settings, and what are the turnover rates? Areas of leadership for other mental health professionals would also be of interest and would be useful in capitalizing on the strengths of each mental health discipline.

There appears to be little doubt both from the subjective-experiential view and from the more objective but limited research view that rural mental health programs and personnel differ from their urban counterparts. For most rural areas, the issues can be summarized as too much space with too few people to provide many services. And as Dunbar (1982a) notes, the smallness, the visibility of the provider and the consumer, and the personal nature of the relationships within the

rural community influence how and what can be provided by the mental health center. Lack of resources, transportation problems, a high-risk population that is politically powerless, and personnel performance expectations that are based on an urban mental health care delivery model are all issues confronted by rural mental health personnel (Bachrach, 1981).

In a national study of 120 community mental health centers, Jones, Wagenfeld, and Robins (1976) investigated rural versus urban mental health workers' attitudes toward 1) community involvement and outreach efforts; 2) the staff perceptions of the role of the center; and 3) the degree of commitment to the ideology of community mental health. Rural workers endorsed community mental health ideology and perceived their centers as being like social agencies rather than medical agencies to a significantly greater extent than the urban workers. They also endorsed the highest levels of both organizational and personal activism (and showed the least discrepancy between the two).

Using the same data, Wagenfeld and Robins (1975) reported on comparisons between social workers employed in settings varying from inner-city urban to highly rural. Based on a sample of 140 respondents, they found the greatest similarity in endorsement of community mental health ideology between inner-city and rural social workers. The rural social workers perceived their mental health organization as requiring activism and as being a social agency, whereas the inner-city social workers saw themselves more strongly than their agency as being the activists. It is possible that the similarity may be based on the fact that both catchment areas are composed of economically deprived

populations; thus in both cases mental health workers are forced to take on activist roles. Of course, not all rural areas are poor, but Davis and Marshall (1979) estimate that while only one-fourth of the American population lives in rural areas, one-half of the nation's poor live in rural areas.

A disproportionate number of rural poor are ethnic people of color (Bachrach, 1981). Sensitivity to cultural diversity and class differences are also important educational components, if the mental health worker is to be effective in helping the rural poor.

Understanding the differences between rural and urban mental health needs and programs and grasping the dynamics by which rural agencies become advocates for social change are not matters of academic interest alone. With the new federalism and the instituting of block grants, it is mandatory that rural nurses and other mental health professionals be active in understanding the political process at the state level and that they sit on decision-making boards for allocation of block-grant funds. If the health professionals do not assume the advocacy role for the well-being of the rural community, there is little chance that the gains made in rural health care services will survive the competition with urban centers for the decreasing resources available.

SUMMARY

The research on the characteristics of rural consumers, providers, and programs needs to be interpreted with caution. Most of the studies focused on particular unique populations, and the methodology used

requires refinement to avoid urban bias. With that warning in mind, the following are the highlights of research on the consumer, provider, and mental health program.

- Rural populations tend to be fatalistic, to believe in subjugation to nature; to see human nature as basically evil; to be oriented to concrete places and things. They are often conservative, religious, work oriented, intolerant of nontraditional beliefs, authoritarian, ethnocentric, and family centered. Social organization focuses on informal face-to-face negotiation.

- Ten percent of the populations surveyed were probably in need of psychiatric help. Little is known about the actual help-seeking behaviors of rural residents or of the informal networks in rural communities that provide counseling and support.

- An inverse relationship exists between prevalence of psychiatric disorder and impairment and socioeconomic status. Psychiatric disorders seem to be correlated with poverty and unemployment. A positive relationship exists between age, race, and psychiatric disorder when disorder is measured as stress (H.O.S. instrument). The poor, the elderly, and ethnic minorities appear to measure higher on stress tests.

- Findings on admissions to mental health centers in Colorado suggest that there may be more similarities between the residents of the most rural and the most urban (inner-city) portions of the state than there are between rural and suburban or mid-sized communities.

- Mental health professionals in rural settings must confront issues that their urban counterparts do not face. Referral resources are often lacking, and there are few opportunities for continuing education. Outsiders are viewed with suspicion. Privacy is often difficult to obtain -- both for the client and for the mental health worker -- and personal and professional roles can easily become blurred. Workers in rural settings report feeling that they are "on call" twenty-four hours a day.

- Research shows that mental health workers who choose to settle in rural areas either grew up in small communities or had some field experience in such a setting. Those who live with a spouse or significant other seem to make a better adjustment to rural practice than those who live alone. To prepare nurses and other psychiatric workers for such practice, a generalist curriculum seems to be in order, including instruction in community dynamics, culture, structure, and politics.

- Research on rural mental health programs consists largely of descriptive reports on programs designed to meet the needs of special populations in particular settings. While it is difficult

to generalize from such case histories, there seems to be little doubt that rural programs differ strikingly from their urban equivalents. Programs tend to be smaller, more visible, and more personal in character. Resources are scarce, transportation often difficult, and the population served poorer and more powerless than in more densely settled areas. The most rural and most densely urban areas seem to have common characteristics, perhaps because of the low socioeconomic status of the populations they treat.

- Workers in rural areas tend to endorse community mental health ideology more strongly than urban workers and see themselves and their organizations as activists involved in social change. That activist mentality may become critical over the months ahead, as urban and rural programs have to battle for resources under the block-grant system.

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USING HEALTH BELIEFS IN A NURSING ASSESSMENT MODEL

by

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Our role as nurses is deeply affected by the health beliefs of the people we treat, by everything from their attitudes toward hygiene, nutrition, and exercise to their feelings about when to seek professional help and whether or not to follow professional advice. Such health beliefs must be acknowledged, understood, and treated with respect. It is the purpose of this paper to present a general model or framework that accounts for such health beliefs and thus may help us to be more effective in assisting our clients to achieve a healthier life.

The use of a general model to guide our practice is particularly relevant in rural nursing practice. In rural sections of the country, physician services are scarcer and must be allocated with more careful attention to the need for such services. The nurse is often the primary

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health care professional in rural communities. Consequently, s/he can best identify what role the health beliefs of clients play in their subsequent health behavior. Thus, the rural nurse occupies a central position for influencing the health behavior and, in turn, the health of rural populations.

Before introducing this framework, some general comments are necessary. Too often we are quick to present our theories and act on them without careful attention to our underlying assumptions or to research evidence. Consequently, I will start by identifying some of the basic assumptions underlying the model that will be presented.

Nursing science has come a long way from the days of trial-and-error methods and word-of-mouth recommendations about what works and what does not work in a myriad of situations. Most of us have come to realize that a general framework for guiding our nursing practice more often results in the desired outcome than if we treat each new patient, client, or situation as unique. The framework that I will describe as a means for understanding the role of health beliefs in seeking health care is a general model of health behavior. My first assumption is that the health behavior of people is central to nursing practice. My second assumption is that the process of deciding on a health-relevant behavior is rational, although the content of the decision may not appear to be. I will discuss each of these assumptions in turn.

Beyond what we do for and to our patients, often in times of acute disability or incapacity, nursing is concerned with assisting and teaching patients to act in a manner which is consistent with good health practices. These practices cover a broad range of activities

and behaviors from basic hygiene, nutrition, and ample exercise -- all of the things that make for a healthy life style -- to seeking appropriate health care for the prevention, detection, and/or treatment of disease. Tied to these latter activities is the important issue of an individual's general adherence to health recommendations and treatment regimes. Hundreds of studies have addressed just this problem -- whether and to what extent people comply with recommended treatments. For example, do people take the full course of prescribed medications? Much to the surprise of physicians, though perhaps not of nurses, various studies have found that anywhere from 19 to 72 percent of patients do not fully comply or follow through with their treatment regimes (Stimson, 1974). Many of these studies addressed the treatment of infections and looked at whether or not the full course of a prescribed antibiotic had been taken. In psychiatric nursing, taking prescribed medication is particularly critical. Frequently, a month or so after a patient has decided to cease taking medications, s/he once again appears at the doors of a treatment agency in a decompensated state. All the advances in medical technology and research are to no avail if a treatment program or health behavior is not carried out.

What do I mean by health behavior? Some authors use the term in a very narrow sense in an attempt to distinguish it from illness behavior or sick-role behavior. According to Kasl and Cobb (1966, p. 246), health behavior is "any activity undertaken by a person believing himself to be healthy for the purposes of preventing disease or detecting it at an asymptomatic stage." They then define illness behavior as "any activity undertaken by a person who feels ill, to define the state of his health and to discover a suitable remedy." Sick-role behavior

is "any activity undertaken by those who consider themselves ill for the purposes of getting well."

I do not find these distinctions entirely satisfactory. First of all, they fail to encompass the broad range of behaviors and activities which serve people's health. In particular, psychologically oriented health behaviors are hard to include in these definitions. Second, I detect a medical-model bias. Health is seen merely as the absence of disease or the opposite of disease and health behavior as avoiding, preventing, detecting, and treating disease. Third, these definitions often imply that health behavior is synonymous with the utilization of health services. In fact, between 70 and 90 percent of self-recognized episodes of sickness may be handled outside of the formal health care system (Kleinman, Eisenberg, and Good, 1978). Add to this the numerous behaviors of a healthy life style, and one can see that health service utilization is only a small part of potential health behaviors. If we want a complete list of health behaviors, we need to add a few more categories to Kasl and Cobb's trilogy. I would suggest six subsets or categories of health behavior:

1) Health Enhancement -- Those behaviors directed at improving one's health (e.g., exercise, meditation);

2) Health Maintenance -- Those behaviors directed at maintaining one's health (e.g., adequate sleep, balanced diet);

3) Disease Prevention -- Those behaviors directed at preventing disease (e.g., immunizations, hand washing);

4) Disease Detection -- Those behaviors directed at detecting disease in an asymptomatic stage (e.g., Pap tests, breast self-examination);

5) Health Restoration -- Those behaviors directed at restoring one's health (e.g., taking prescribed medications, staying home when ill);

6) Health Detriments -- Those behaviors known to endanger one's health (e.g., smoking, excessive drinking).

None of these categories, by definition, requires the use of formal health services. The examples were selected to illustrate this point. Rather, health services utilization may occur under any of these categories.

In contrast to viewing illness behavior and sick-role behavior as normative, these constructs consider such behaviors as part of health restoration, which includes all the behaviors directed at restoring one's health in times of illness. Kasl and Cobb's definitions do not account for health enhancement or health maintenance; nor do they distinguish between disease prevention and detection. Their three-category formulation also ignores health detriments. These are behaviors that we know to be harmful to our health, such as smoking and excessive drinking. In this category, the health behavior consists of <u>not</u> doing harmful things, rather than doing beneficial things. The process is presumably similar to the more active pursuits described in the first five categories.

These six categories or subsets of health behavior improve on Kasl and Cobb's definitions by providing a more comprehensive consideration of the potential health behaviors nurses are concerned with in their practices. They broaden our perspective beyond the limited scope of the medical model, with its nearly exclusive focus on disease and the use of medical services. They identify a fuller range of motivations and goals with respect to health, and health is not restricted to the physical sphere. Finally, they lead us to an overriding definition of health behavior. Health behavior is any activity which has as one of its consequences an effect on the individual's health.

This definition clearly implies that the only thing that distinguishes health behavior from any other form of behavior is its effect on health. While this reasoning may sound simplistic, it allows us to extrapolate from theories of human behavior which have been articulated in the social-science literature for years and for which there is a fair amount of research evidence. I see no reason why nurses must reinvent the wheel. Indeed, I believe that our unique contribution lies in our ability to take theories generated by the social, biological, and physical sciences and apply them to health care.

If the processes that lead to various health behaviors are no different from those that help explain any form of human behavior, then our task is to look at theories of human behavior and to choose the perspective that we find most useful in application to health-relevant acts. The perspective that I have chosen is a cognitive behavioral one. This approach combines the principles of behavioral theory with a phenomenological or cognitive perspective. In its most elementary

form, behavioral theory asserts that people will tend to do those things that have been reinforcing or rewarding in the past and will tend not to do those things that either have been punishing or have failed to result in a desired reward. A phenomenological or cognitive approach asserts that the perceptions of the individual have a central organizing role in defining these situations and in determining what is rewarding and what is punishing.

In other words, we are not black boxes, all responding to the same stimuli in the same manner. Rather, we add our own unique perspectives, perceptions, and interpretations. By combining the cognitive or perceptual element with the tenets of behavioral theory, we do not have to accept the assumption that all behavior is rational in its content. Nurses and laymen alike know that health behaviors are often irrational. Is it rational for people to smoke? For diabetics not to adhere to their diets? Of course not. Yet people do smoke, and diabetics don't always follow their diets. By allowing for individual perceptions, we only have to accept the assumption that the process of deciding to act one way or another is rational. The content need not be and, indeed, often is not.

An example that illustrates this distinction between rational process and rational content comes from my clinical experience in a psychiatric setting. Shortly after her admission to the hospital, a patient was discovered in her room, sitting on the floor, encircled by her own feces. Some days later, when she was more approachable and a little more verbal, we talked about that episode. What emerged was that she was frightened of people and felt a strong need to keep them

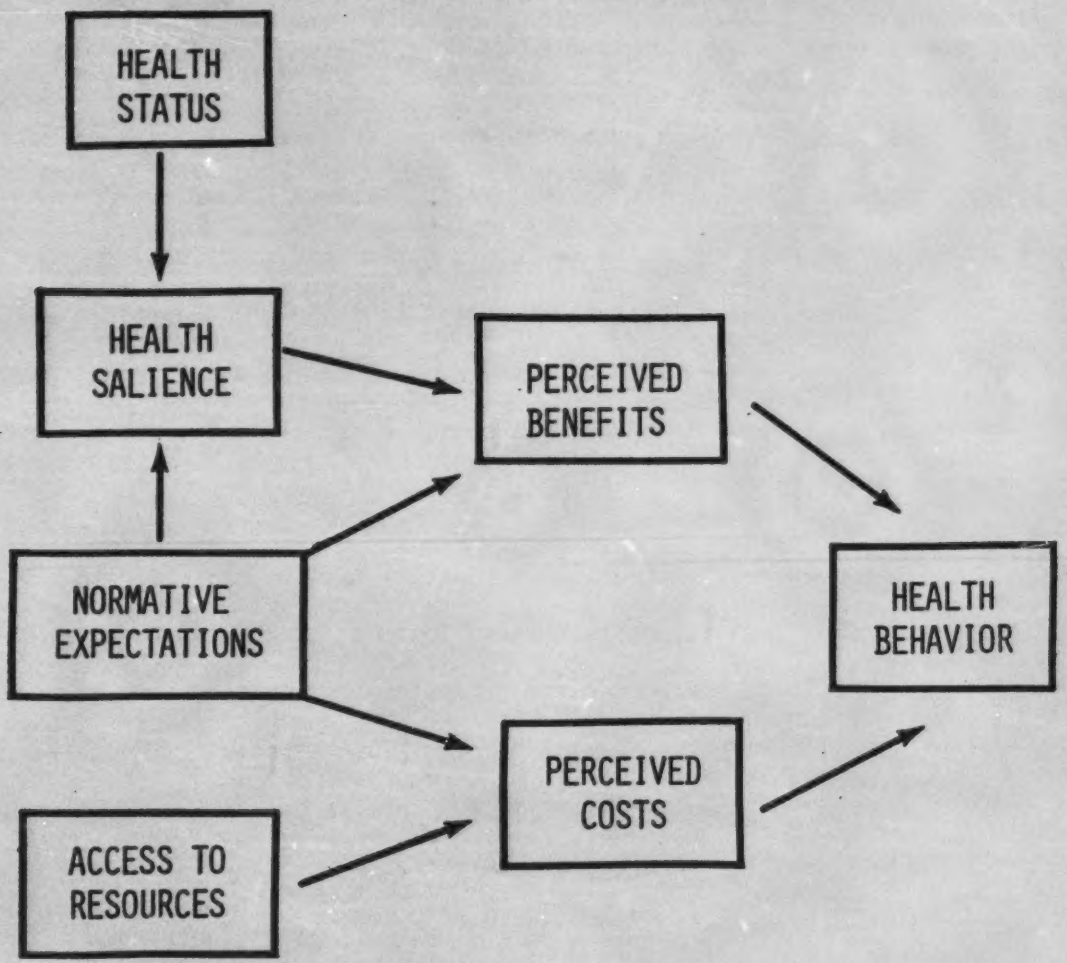
away. The only thing she could think of to achieve this end was to surround herself in feces. In terms of the process, she had a goal, and she came up with a means that achieved that goal. But in terms of content, we would not call her behavior rational -- there are better ways to let it be known that you want to be left alone.

To review, I am asking you to accept two assumptions: 1) the health behavior of people as defined here is central to nursing practice; and 2) the process, but not necessarily the content, of people's decisions whether or not to engage in any health-relevant behavior is rational.

A GENERAL MODEL OF HEALTH BEHAVIOR

The conceptual model of health behavior in Figure 1 represents this process of deciding whether or not to engage in a particular health behavior. I do not mean to imply that each act is consciously and deliberately thought out. Rather, if we were to probe such a decision, the model represents what might go on in a person's head. Basically, this model says that a person will weigh the benefits and the costs of a particular behavior -- for example, getting a dental checkup, having a Pap test, exercising, seeking psychotherapy -- and will engage in the behavior if the benefits of doing so appear to outweigh the costs. This point is fairly straightforward. What is important to remember is that the <u>perceived</u> benefits and the <u>perceived</u> costs are at issue, not the logical or factual assessment of objective benefits and costs. Health beliefs play a major role in these perceptions.

FIGURE 1: A CONCEPTUAL MODEL OF HEALTH BEHAVIOR



We are not concerned for the moment with whether or not a Pap test can detect cancer in the early stages or whether or not psychotherapy leads to higher self-esteem or a happier life. Rather, the question is whether or not a particular patient or client believes that detecting cancer in the early stages is important or that a happier life and higher self-esteem are desirable.

Although perceiving the benefits of performing a health behavior is necessary, it is not sufficient. Against these perceptions of benefits, we must weigh the perceived costs -- e.g., the discomfort of a pelvic exam or the embarrassment of discussing one's problems with a psychotherapist. Even though one may perceive many benefits in a health behavior, if the perceived costs are sufficiently high, the behavior may still not be performed.

It should be stressed that perceived costs do not refer to actual dollar costs or time costs. These factors enter elsewhere into the model. At issue here are the individual's subjective assessments. Those familiar with the health behavior literature will recognize the model presented here as similar to the Health Belief Model -- a model which has received considerable attention over the past twenty years (see Becker, 1974; Kirscht and Rosenstock, 1979). The general model of health behavior proposed here was developed, in part, from my critique of the Health Belief Model (Aaronson, 1980). In that statement I identified the ways in which the nearly exclusively social-psychological focus of the Health Belief Model limited research evidence support for that model. Our present task is to demonstrate how this general model

of health behavior can be used as a nursing assessment tool. It is to this task that our attention now turns.

ASSESSING PERCEIVED BENEFITS AND COSTS

There are several dimensions or aspects to perceived benefits and perceived costs which can be organized into a series of assessment questions. Nurses can ask these questions of themselves and of their clients as well as use them to assess the situation to determine the individual's perceptions of the costs and benefits in practicing the particular health behavior.

The first four questions address the behavior itself. We need to assess aspects of actually engaging in the behavior or, in the case of health detriments, of not engaging in the behavior. These are:

1) How easy or difficult is the health behavior for this person?

2) How comfortable or uncomfortable is the health behavior for this person?

3) How pleasant or unpleasant is the health behavior for this person?

4) How important or unimportant is the health behavior for this person?

By asking these questions, we may discover, for example, that an elderly person skips medications on days when arthritis makes opening

the medicine bottle difficult and painful. Such questioning helps us focus on the barriers to health behavior for a particular individual. Once these are identified, we have information with which to intervene in a given situation. For example, for the arthritic, we might obtain pill containers that are easy to open.

The "importance" and "difficulty" dimensions of perceived costs and benefits addressed by Questions 1 and 4 are more cognitive than the dimensions tapped by the other two questions. However, they are still subjective. For example, we may think the behavior is very important, but what does the patient or client think? Does s/he know why s/he is being instructed in a particular health behavior? Assessing "importance" directs our attention to the health teaching needs of our clients.

Assessing "difficulty" similarly identifies the need for intervention. The aspects of perceived costs and perceived benefits tapped by Questions 2 and 3 are more clearly affective. They involve subjective feelings and attitudes toward the behavior itself. Assessing these issues is one way nurses identify clients' needs for support.

Perceptions of costs and benefits also entail an assessment of the consequences of the behavior. Once again, we must address the individual's perceptions, not necessarily objective facts. Questions one would ask include:

1) How valuable or worthless are the consequences of the health behavior to this person?

2) How rewarding or punishing are the consequences of the health behavior to this person?

3) How beneficial or harmful are the consequences of the health behavior to this person?

4) How important or unimportant are the consequences of the health behavior to this person?

The consequences of a health behavior are not all health related. For example, Graham (1976) investigated why some pregnant women did not stop smoking during pregnancy despite their knowledge of scientific evidence that supported the recommendation to stop, not only for the sake of their own health but also for that of their unborn infants. Variations on the same theme repeatedly emerged. "If I quit smoking, I would be so grouchy and so irritable that it's going to alienate my relationship with my husband," or "I'm not going to be a very good mother to my other children if I try to quit," or "I can't handle that now." We must be sensitive to and aware of such non-health-related consequences of health behaviors when assessing their contribution to an individual's perceptions of benefits and costs.

The last major assessment question directed at identifying the individual's perceptions of benefits and costs involves the subjective efficacy of the behavior. That is, does the person believe the health behavior will lead to the desired health outcomes for him or herself? People are obviously unlikely to follow advice that they do not think will work.

To summarize thus far, in assessing perceived costs and benefits, we want to know what this person sees as good about the health behavior and its consequences and what s/he sees as bad. To the extent that we can identify these attitudes, we will be better equipped to determine what is impeding the person from actually carrying out the behavior and to intervene appropriately.

All of the other elements in the model are the factors that influence the individual's assessment of the perceived benefits and perceived costs of carrying out the health behavior. This influence is represented in Figure 1 by arrows drawn from these factors to the perceived benefits and costs boxes. Each of these factors also needs to be assessed.

HEALTH SALIENCE

Health salience refers to a general individual predisposition to attend to health concerns. When we assess this factor, we also ask a series of questions.

1) How important is health to this individual?

2) Does the individual believe s/he can control his or her health?

3) How susceptible to health threats does the individual believe himself or herself to be?

4) How seriously does s/he take these threats?

First, does the individual value health very highly? Few people will say, "No, I don't care about my health." However, the issue is not so simple. We do not hold all of our values in isolation. When researchers ask people to rank health in competition with other values, such as spiritual needs, comfort, financial security, and a good family life, health does not always come first (e.g., Wallston, Maides, and Wallston, 1976).

In assessing health salience, we also want to know whether an individual believes that he or she can control his or her own health. It is very hard to convince people to behave in a particular manner when they do not believe that anything they do is going to have an effect. They may believe that fate or chance or other people control what happens to them. They may say, "Look, if I'm going to get sick, I'm going to get sick; there is nothing I can do about it." From a research perspective, the multidimensional Health Locus of Control Scales (Wallston, Wallston, and De Vellis, 1978) are useful for measuring this aspect of health salience.

Last, to assess health salience, we want to ask how susceptible the person believes s/he is to various health threats and how serious these threats appear. These questions direct us to the specifics of the particular health behavior we are concerned about. For example, if we are promoting vaccinations against measles, how susceptible does the individual believe s/he is to measles? How serious would it be for him or her to actually get measles? The answers to these questions will inform us about how likely that individual is to perceive benefits in obtaining the vaccination.

These concepts of seriousness and susceptibility are derived from the Health Belief Model developed by Kirscht and Rostenstock (1979), Becker (1974), and others. However, the path of their influence on health behavior is distinctly different in this model. Rather than standing alone as concepts, they are considered, along with the relative value of health and health locus of control, as indicators of health salience. Thus, to say that health is salient to someone is to say that s/he values health highly, relative to other values; that s/he believes s/he can affect his or her health; and, in some instances, that s/he believes s/he may be susceptible to a health threat that would be serious. In the general model presented here, if health is salient, then the individual is more likely to perceive benefits in carrying out a health-relevant behavior (see Figure 1).

HEALTH STATUS

People do not arrive at these beliefs with respect to health salience in a vacuum. One factor which affects their perspectives is health status. Health status is fairly straightforward. If someone feels sick or is in pain or has a history of a particular health problem, then these things serve to make health more salient, at least for a time. Dental care is a good example. The perceived costs of going to the dentist are very high for some people. However, if one has a bad toothache, suddenly the salience of that pain, or the decrease in one's immediate health status, results in an increase in perceived benefits which may override those initial high costs.

NORMATIVE EXPECTATIONS

A second factor that influences health salience is normative expectations. As can be seen in Figure 1, normative expectations affect not only health salience but also both perceptions of benefits and perceptions of costs.

Normative expectations derive from relations with one's friends, family, and health care providers, and from general cultural or subcultural beliefs. They represent the social group's influence on the individual as well as the collective health beliefs of an individual's social milieu. Normative expectations can be measured by further assessment questions.

1) Do family members and friends practice the health behavior?

2) Do family members, friends, and health care providers encourage the individual to practice the health behavior?

3) Do family members, friends, and health care providers support the individual for practicing the health behavior?

4) What are the individual's subcultural beliefs and practices with respect to the health behavior?

For example, do family members and friends get immunizations, exercise regularly, quit smoking, seek psychotherapy? A number of research studies have found that if one person in a family practices a particular behavior (e.g., obtains a vaccination against polio, gets preventive dental checkups) then it is more likely that the other

members of the family will do the same (Tyroler, Johnson, and Fulton, 1965; Freeman and Lambert, 1965; Picken and Ireland, 1969).

Because many health behaviors are not applicable to other family members, we also want to inquire about whether family members, friends, and health care providers encourage and support the health behavior. Encouragement may be inappropriate if the individual is practicing the health behavior. It might even be viewed as nagging if carried to extremes. Support, on the other hand, is nearly always positive and reinforcing. Schmidt (1977) offers research evidence that support and encouragement from family members are associated with higher rates of compliance with treatment regimes.

To the extent that the answers to Questions 1 through 3 are yes, then the individual should perceive greater benefits for practicing the health behavior than if the answers are less affirmative. Normative expectations have this influence for two reasons. One, we like to do the things that people important to us do. And two, when we do things that please people important to us, they reward us with their approval, their love, and other positive reinforcements. However, if these people do not practice the health behavior or do not encourage us or support us in doing so, then the perceived costs of the behavior will go up for corresponding reasons. First, it is very hard to do something that our friends and family do not do. Second, it is even harder to go against what everyone who is important to us thinks we ought or ought not to do. For example, a current health recommendation for pregnant women is to abstain from all alcohol. If, however, a woman's entire social circle frequently indulges and frequently offers her a

drink, it is very hard for her to practice the appropriate health behavior, to abstain from alcohol consumption. It would help if alcohol were less accessible, but that is often unrealistic. The support and encouragement of friends and family, if present, should help the pregnant woman perceive greater benefits in abstaining.

Normative expectations have their roots in cultural or subcultural beliefs. For example, I grew up believing in the curative powers of chicken soup. Now, when I get sick, the first thing I do is make some chicken soup. I believe it's good for me, I think it's going to help, and I perceive all sorts of substantial benefits from it. Because I am unaware of any scientific evidence that would lead me to believe that chicken soup is contraindicated, I do not have too much difficulty with this health belief and behavior.

Sometimes, however, subcultural beliefs may, on scientific grounds, be contraindicated. When that is the case, our job is much harder. We cannot just say, "Don't do it." We need to attend to the difficulty that such contradictions present for the individual when everyone s/he knows is giving the opposite advice. For example, pica is practiced by some groups during pregnancy. The best we can do, at times, and it is often very helpful, is to explore with the person how difficult it is not to do what everyone expects you to do. Even if the individual understands what you say and comes to see the benefits of following a recommendation that goes against friends and family, s/he does incur costs. By perceiving and experiencing higher costs than a person whose social group is not alienated by the behavior, the in-

dividual must perceive correspondingly greater benefits in order to choose to behave in the "healthy" manner.

Although the existence of different culturally based health beliefs is acknowledged by this model, it does not address the content of such beliefs. Nurses must acquire a working knowledge of culturally based health beliefs and practices among the populations they serve. When we bring this information to the situation, we can assess the extent to which the individual subscribes to the subgroup's beliefs and practices and use this knowledge to determine whether such pressures create facilitative or inhibitive normative expectations for the individual.

ACCESS TO RESOURCES

Many complex social factors confront us when we address a topic like health behavior. One of the issues that greatly concerned me when I started in this field was its susceptibility to a victim-blaming ideology. Such an attitude says, "It's your fault if you're not practicing the right health behavior. There is no one to blame but yourself." I believe that perspective is not only damaging, it is also in error.

The last element in the model, access to resources, accounts for many social factors beyond the individual's control. Health beliefs have the least influence on access to resources. This element represents the influence of the social structure on the individual's decision. The components of access to resources are: income, health insurance, education, having a regular source of health care, travel

time and distance to health care facilities, waiting time to see a health care provider, and the individual's past behavior and habits.

The jobs we hold, the money we make, and the amount of formal schooling we obtain are all greatly influenced by the social structure. That health behavior is positively associated with income and education does not mean that we can simply advise people to get better jobs, make more money, or get more education. These factors are rooted in the social structure, and that is where intervention must be directed if we are to alter the damaging effects of poverty and its associated ills on large numbers of people. The social structure does not always allow the individual to act in his or her own interests. Many of the components of access to resources can be reduced to availability or lack of availability. It is difficult to obtain health care if it is not available for economic or other reasons.

Access to resources does not entail the kind of assessment questions we asked of the patient under the other components of this model. Rather, we must focus on the situation. It is not the individual who determines where health centers are located or how they are equipped. These decisions are made by a larger social system. Health resources cost money. Those people without money will have less access to such resources. It is difficult to buy nutritionally adequate meals if you do not have enough money. It is difficult to buy sporting equipment and find recreational facilities for all those activities that keep us fit. Health insurance may serve as a substitute for money to purchase health services. However, health insurance is not always a matter of personal choice. Most of us, although not all, get our health

insurance through our jobs. Thus, the unemployed are in double jeopardy. Not only do they lack jobs that offer health insurance, but they have no money to purchase health care and other resources.

Another variable under access to resources is having a regular source of health care. The literature trumpets the finding that people are more likely to use health services if they have a regular source of health care. By itself, such a finding does not offer us much insight. The model presented here asserts that if you have a regular source of health care to go to when you are sick, your access is greater. This greater access results in lower perceptions of costs, which in turn make it more likely for you to go to a health care provider. If you do not have such a source, you will be less likely to go to a health care provider when you need one for corresponding reasons. Your restricted access will result in your perceiving greater costs in doing so.

Some aspects of access to resources do involve the individual more directly. Travel time and distance and waiting time can be objectively measured. However, such costs are differentially evaluated. Because people respond differently to the time and distance factor, they experience differences in their perceived costs. Last, the individual's own past behavior or habits also involve access. If you have practiced a behavior, your future access to it is more readily available. You do not need to learn a new behavior, a process that would increase your perceived costs.

In sum, all of the access variables in the general model affect perceived costs. Having money or a regular source of health care, for example, does not mean one will perceive greater benefits in a health

behavior. It does, however, mean that one's perceived costs will be decreased.

Access to resources is particularly critical for rural nursing. In the United States, rural residents have a lower median education and a greater frequency of incomes below poverty levels than do residents of urban areas (U.S. Census, 1970). A larger percentage of rural residents than of urban residents are not covered by any health insurance program, including Medicaid, and rural areas have fewer physicians, dentists, and nurses per population base than do urban areas (U.S. Department of Health, Education, and Welfare, 1978).

The rural nurse is faced with a formidable task. S/he must work with a population that is initially disadvantaged by low access to health resources. This restricted access creates higher perceptions of costs. Rural residents need to perceive substantial benefits in practicing a health behavior if they are to override their perceptions of costs and behave in the recommended manner. If the rural nurse attends to the issues and asks the questions raised, if s/he uses the general model of health behavior presented here as an assessment tool, s/he may be more successful in assisting people to master and to perform desired health behaviors.

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INTERVIEWING THE RURAL COMMUNITY TO DETERMINE NURSING NEEDS

by

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INTRODUCTION AND BACKGROUND

The assessment of community needs for nursing services represents a vital component of nursing practice that impacts on a variety of aspects of care. Certainly assessment data are critical in the planning, implementation, and evaluation of community-relevant nursing services. The planning process involves program development, staff distribution, and training. Nursing needs assessments are also extremely useful in nursing education, providing the student with concrete information on the "real world" nursing challenges s/he may face in practice. The assessments should serve to guide curriculum planning, thus insuring a community-sensitive, dynamic nursing education program. Finally, nursing needs assessments can serve a much-needed function as a primary tool in nursing research. Using such a tool, nursing needs and care can be scientifically tested and evaluated, providing a way of

empirically measuring the nursing process. Such research can serve to better define and justify the strengths and uniqueness of nursing practice. Thus, the concept of the nursing needs assessment has broad implications in nursing practice, education, and research.

To date there are a limited number of available nursing needs assessment tools. Traditionally, community needs assessments often take a medical, disease-oriented approach, addressing such parameters as incidence and prevalence rates, provider/population ratios, and morbidity and mortality rates. This approach is certainly valuable but is limited. Missing are both the nursing/health-oriented perspective and the critical and often neglected consumer view.

The nursing needs assessment tool to be described in this report was developed in part in response to the need for a consumer- and nursing-oriented measurement tool. The development of the methodology took place within a larger project aimed at assessing the need for public health nursing services in the state of Wyoming. A major goal of the project was to develop a model for estimating comprehensive staffing needs in public health nursing. Along with the use of the nursing needs assessment, interviews were conducted with nursing administrators, nursing staff, and other relevant community health and human service providers including physicians, school nurses, social workers, and hospital administrators. This one-year project was funded by the Wyoming State Department of Health and Human Services and conducted by the University of Wyoming School of Nursing and the College of Human Medicine.

The nursing needs assessment presented here is built on a conceptual framework that views people and health in a holistic fashion within the total environment. It is designed to identify what nursing contributes or can contribute toward a health-promoting interaction pattern. It is hoped that this needs assessment tool may serve as a point of departure for others in the field of health care who wish to do similar measurements on their own populations.

The tool is based on three approaches. First, building on an ethnoscience approach, it takes disruptions in daily living as indicators of levels of health and wellness (Leininger, 1978 and 1979). Previous research by two of the authors had used the more traditional approach of asking questions about individual health problems. There were gross discrepancies between the data generated with this "problem" orientation and later reporting of visits to health care providers and less structured observations of the interviewers. People tended to seek help for phenomena that they had not reported as problems.

The decision to ask about events that interfere with daily living was an attempt to better reflect the world of our subjects. Using this conceptual approach, then, one goal of our investigation was to test the methodology, to see if information regarding alterations in daily living could be gathered accurately and effectively and if it could be useful in describing health and nursing needs in defined populations.

The second conceptual tenet of this tool is the importance of self-care. Orem (1971) and others have examined self-care and its relevance to contemporary nursing. In that our tool was developed to be used in a largely rural state, such practices are particularly

critical. In isolated and underserved areas, the use of self-care knowledge on the part of consumers has been a long tradition as well as a necessity. It was felt that one way to plan effective and culturally relevant nursing services was to discover and analyze the existing self-care practices of a client population and to establish nursing services congruent with this natural pattern, designed to facilitate, accelerate, and perhaps alter existing practices. Thus, an additional goal of our methodology was to determine if self-care patterns could be identified and if they proved useful in the planning of community nursing services.

The third conceptual basis of the nursing needs assessment is the consumerist approach of assessing potential clients' knowledge and attitudes: their concepts of health, their estimates of levels of health in their communities, and their views on the role and functions of the public health nurse. This approach involves measuring the level of public knowledge of available nursing services and determining marketing strategies that promote high levels of public knowledge. In working toward the overall goal of the project -- estimating staffing needs -- the assessment put great stress on consumer estimates of public health nursing needs based on their understandings and perceptions of the public health nursing role and potential in their communities. This consumer-oriented perspective serves to strengthen the validity and relevance of the nursing needs assessment to the communities served.

In summary, the nursing needs assessment was developed as a methodological tool to measure community health patterns and nursing

needs. Based on the concepts of disruption in daily activity, self-care, and consumer knowledge, this tool was designed to guide and facilitate nursing practice, education, and research. The purposes of this paper are to describe methods of data collection and analysis and to make suggestions for how the tool might be utilized by others in the field of nursing.

DATA COLLECTION METHOD

The nursing needs assessment protocol (See Appendix) was designed according to the above tenets by the authors in collaboration with nursing administrators, staff, educators, and others. Protocols were used in ninety-nine in-person interviews. Written consent from respondents was obtained, and replies remained anonymous.

Ideally, questioning should have followed a strict pattern: first an open-ended inquiry with the response recorded verbatim, then a more structured question using specific probes. This procedure would have allowed analysis of the first response as well as systematic analysis of specific factors. Unfortunately, a systematic interviewing process was not used. More closely controlled field work could overcome the limitations of the method used.

Initially, demographic data were collected on the respondents' families, including information on residence patterns and family support systems. These data were felt to be vital in a rapidly changing, highly mobile state such as Wyoming. Next, the respondents were questioned on their personal definitions of health. Differences between how they viewed health in men, women, and children were sought. Third,

the respondents were asked to identify events that had altered their families' daily activities during the past year. The interviewers probed for health-related events that might potentially disrupt daily activities (accidents, life crises, alcohol overuse, illness, social isolation, continuous low-level anxiety, and pregnancy). These categories of events were derived from several data sources: state morbidity and mortality statistics, the authors' ethnographic observations, and the opinions of public health nursing supervisors. Varied perspectives were combined to develop a list of disruptions thought to have a high occurrence among Wyoming residents and to be relevant to the practice of public health nursing.

The activities of daily life that were identified and used in the probing process included: sleeping or resting, eating or appetite, mobility, elimination, work/school attendance or performance, social activity, and interactions with friends or family. Discussion of sexual activity was not included because it was felt to be a socially sensitive area that might destroy the interviewer's rapport with subjects. Having mentioned a life-style-altering event, the respondent was then asked to identify the type of activity disrupted, what the affected person did or did not do about the disruption, what other people did about the problem, and, finally, if the disruption was solved and how it was solved. Figure 1 illustrates a typical response to this question.

Respondents were next asked to describe typical life-altering events in their communities. They were asked to identify these events, the type of disruption produced, the kinds of people affected, what the

FIGURE 1: A TYPICAL DESCRIPTION OF FAMILY DISRUPTION

INITIALS OF FAMILY MEMBER	EVENT INTERFERING	TYPE OF ACTIVITY DISRUPTED - DURATION	WHAT DID S/HE DO ABOUT IT?	WHAT DID OTHERS DO ABOUT IT?	HOW WAS THE PROBLEM SOLVED?
B.B.	Pregnancy/ Childbirth	Quit work Nauseated Too tired to do housework Got up at night to feed baby	Ate small meals Took naps	Husband helped with housework, feeding Nurse advised on nausea, helped prepare for childbirth and infant care	Baby delivered Baby now sleeps through night

FIGURE 2: A TYPICAL DESCRIPTION OF DISRUPTION IN THE COMMUNITY

EVENT	TYPE OF ACTIVITY DISRUPTED	KINDS OF PEOPLE AFFECTED (BY AGE, SEX, OCCUPATION, ETC.)	WHAT DO THEY DO ABOUT IT?	WHAT DO OTHER PEOPLE DO ABOUT IT?
Divorce	People change homes Change circle of friends Woman goes to work Children act out More drinking	20- to 40-year-olds All incomes and occupations	Lean on friends and family Seek counseling at Mental Health Center Talk to clergy	Friends and family listen and support (child care; help find housing, job) Counselors teach coping methods and encourage expression of feelings

affected people did about the problem, and what others did. Figure 2 illustrates a typical response to this question. To obtain further specific information on health care utilization patterns, respondents were asked to identify all encounters between any family member and any health care provider over the past year and the circumstances of those encounters. Figure 3 illustrates a response to this question.

FIGURE 3: A SAMPLE DESCRIPTION OF HEALTH CARE UTILIZATION

FAMILY MEMBER	PROVIDER	SPECIALTY	NUMBER OF VISITS PER YEAR	NUMBER OF ADMISSIONS, TOTAL DAYS, PROBLEMS, SURGERY, SERVICE, OTHER
B.B.	M.D.	Ob. Gyn.	20	Full-Term Pregnancy
B.B.	P.H.N.		10	Expectant Parents Classes
B.B.	D.D.S.		2	Check-up
A.B.	O.D.		1	Check Glasses
C.B.	M.D.	Pediatrician	2	Well Baby Check-up
C.B.	P.H.N.		2	Immunizations

The latter part of the protocol deals with consumer knowledge and attitudes. First, the respondent was asked about typical activities that community members engaged in that promoted health. Next, the respondent was questioned regarding family contacts with public health nursing. If a contact had been made, impressions of the quality of care were explored. The respondent was then asked to give his or her view of what public health nurses should do. Exploring community needs, s/he was asked to identify the major health problems in the

community. The responses sometimes overlapped those describing community disruptions. In relation to those problems, the respondent was asked what a public health nurse could do and to estimate the number of public health nurses needed in the community. The interviewer probed to document what criteria or parameters the respondent used in formulating that estimate. Next, the respondent was asked whether certain public health nursing programs/services were available in the community, and, if so, how the respondent knew about them. Finally, the respondent was asked to identify which, if any, of those programs the family had utilized in the past year.

Several subjects were interviewed in each county of Wyoming, totaling ninety-nine respondents. They were selected at random through "on-the-street" interviews. This sampling method assumes that any resident of a small, rural community is similar enough to other residents and knowledgeable enough about all aspects of community life that s/he can accurately define variables. In this study, for example, it is assumed that a respondent can accurately list the major health problems of his/her community. For some purposes (methodological and exploratory analysis), this sample can legitimately be defined as a population. However, the lack of systematic sampling from a defined population precludes direct generalization to any other defined population. The interviews took approximately fifteen to thirty minutes to complete. They were conducted by three interviewers over a period of four months.

SAMPLE ANALYSIS PATTERN

In that the focus of this report is to describe the methodological development and utilization of a community assessment of nursing needs, results presented will be brief and for the specific purpose of demonstrating the feasibility of the tool. Readers interested in fuller elaboration of the results of the study are referred to the technical report by Kennedy and Taheri (1981) from which all of the following tables and data are drawn.

Selected Events and Their Interference with Daily Activities

In the study, it was possible to obtain data related to the occurrence of selected events (accidents, crises, alcohol overuse, illness, social isolation, low-level anxiety, pregnancy, chronic conditions) and to specify types of activities disrupted by these events.

Of the 315 people comprising the total population sample, 89.5 percent were accident free, 8.9 percent had had one accident, and 1.6 percent had had a maximum of two accidents. In terms of the percentage of people who indicated that this caused a disruption in their daily activities, 0.3 percent, or one person, indicated a disruption of four usual daily activities, and two cited interferences with two usual daily activities. Six percent stated that the accident had only disrupted one activity, and the majority said that the accident had not caused any difficulty in carrying out daily activities.

As shown in Table 1, these accidents resulted primarily in disruptions to mobility and work/school activities. Accidents are of particular concern in Wyoming, where they are the leading overall cause

of death in some age groups. Data describing the frequency of other events varied. As might be expected, illness contributed significantly to disruptions in daily living. Methodologically, it is important to mention that in analysis we separated acute and emergent illness from chronic conditions, because it was felt that the impacts of the two categories on daily life and on nursing services were quite different. Respondents simultaneously reported chronic conditions such as arthritis a fair number of times. This might be an even more salient category in other, older populations.

TABLE 1: INTERFERENCE IN SPECIFIC ACTIVITIES OF DAILY LIFE CAUSED BY ACCIDENTS
(N = 34)

INTERFERENCE	NUMBER	PERCENT*
None	12	35.3
Mobility	11	32.4
Work/School	9	26.5
Elimination	2	5.9
Social Activities	2	5.9

*These percentages are based on a denominator of 34, the total number of accidents reported. Any one respondent could supply multiple responses.

If the intended process of 1) asking the open question; 2) recording the exact response; 3) using the probes; and 4) recording the responses to the probes separately had been consistently followed in the field, further ethnoscience analysis of these data would be possible. Although coding such data through content analysis is a complex, time-consuming process, it may be valuable. The research method used was designed to be consistent with a clinical emphasis on culturally prescribed nursing. Use of the method in research not only

contributes to development of an emerging culturally relevant methodology and data base but, in itself, represents convergence between research and practice.

Self-Care Health Promotion Activities

Consumer knowledge of community health dynamics was addressed in several questions. Responses to the question on health-promoting behaviors commonly practiced in the respondent's community are presented in Table 2. This table illustrates a set of activities overwhelmingly comprised of health-promoting self-care behaviors. A few people (six) mentioned use of public health nursing services, though the type of service was not specified. Twenty-one respondents (22.1 percent) mentioned use of medical services or illness care as a way of staying healthy.

TABLE 2: HEALTH PROMOTION ACTIVITIES OF PEOPLE IN WYOMING COMMUNITIES (N = 95)

TYPE OF ACTIVITY	NUMBER OF RESPONDENTS CITING BEHAVIOR	PERCENT OF RESPONDENTS CITING BEHAVIOR*
Exercise	40	42.1
Outdoor Activity	39	41.0
Use of Medical Services or Illness Care	21	22.1
Other Preventive Behaviors	18	19.0
Nutrition	14	14.7
Social Activities	7	7.4
Public Health Nursing Services	6	6.3
Other	19	20.0

*These percentages are based on a denominator of 95, the total number of persons responding. Any one respondent could, and most did, supply multiple responses.

Health Problems of Communities

Another kind of data useful as a basis for culturally relevant nursing services is the client population's perceptions of community health problems. Because the data were drawn from responses to open-ended questions, categories were developed through content analysis. These data were reported in more detailed categories in the technical report: only the summary table (Table 3) is presented here for illustration.

TABLE 3: PERCEPTIONS OF MAJOR COMMUNITY HEALTH PROBLEMS (N = 83)

PROBLEM	NUMBER OF RESPONDENTS CITING PROBLEM	PERCENT OF RESPONDENTS CITING PROBLEM*
Overt Physical Pathology	44	53.0
Substance Abuse	31	37.3
Primary Prevention	22	26.5
Environment	16	19.3
Psychosocial	14	16.9
Care Accessibility	4	4.8
Generalized Care	3	3.6
Other	12	14.5

*These percentages are based on a denominator of 83, the total number of persons responding. Any one respondent could, and most did, supply multiple responses.

The most frequently mentioned community health problems were physical pathologies, with cardiovascular problems, cancer, and assorted minor illnesses such as colds being cited most often. The next most frequently mentioned category was substance abuse.

A more detailed breakdown of the data shows that alcohol abuse was by far the most frequently mentioned single health problem. It was

cited by 35.5 percent of respondents. The next most salient complaints were cardiovascular problems and cancer, each mentioned by 19.7 percent of respondents.

While this finding is important in itself, it also has methodological significance when considered in combination with other observations. In the data reporting events interfering with activities of daily living, only 4 of the 315 subjects were reported to have any problem with alcohol abuse. Perhaps alcohol consumption was seen as a problem that did not interfere with daily life. Perhaps our respondents were telling us that they and their families had no problems with alcohol, but that a lot of other people did, to the extent that alcohol abuse was cited as the major community health problem. The discrepancy may be due to the fact that questions dealing with one's own health problems are more difficult to answer than those discussing other people. To ask a person if s/he or anyone close to him/her has a "problem" is culturally sensitive. A response that says "I have no problems and my family has no problems, but other people do" would fit with the popular (though not well-documented) idea of a macho self-reliance among Wyoming people. The statistical discrepancy illustrates the importance of examining one's tools and interpreting data within a cultural context.

Perceptions of Public Health Nurses

Immediately following the question on major health problems of the community, respondents were asked what they thought public health nurses could do to help alleviate these problems. The first, most obvious overall question to be addressed from the spontaneous responses

TABLE 4: PERCEPTIONS OF THE ABILITY OF PUBLIC HEALTH NURSES TO HELP WITH COMMUNITY HEALTH PROBLEMS (N = 99)

CAN P.H.N. HELP?	NUMBER OF RESPONSES	PERCENT OF RESPONSES
Yes	48	48.5
No	5	5.1
Maybe	1	1.0
Don't Know	6	6.1
No Response	39	39.4

is whether or not a public health nurse was seen as able to help. Table 4 examines this issue.

Only about half of the respondents definitely thought public health nurses could help, and 5 percent thought they could not. Unfortunately, interpretation is clouded by the fact that there was no response recorded for 39 percent of the respondents; it is not clear whether this category reflects the fact that the person was not asked the question, that s/he responded negatively, or that the interviewer simply did not record the response. It is possible, however, to review the content of the responses of those who did think public health nurses could help. The roles these respondents perceived for public health nurses are presented in Table 5. Prevention of illness is the most frequent response, with a caring role second and direct services third.

In the technical report (Kennedy and Taheri, 1981), these data were organized in part for comparative analysis. Consequently, some of the categories have very few or no positive responses.

TABLE 5: PERCEPTIONS OF WHAT ROLES WYOMING PUBLIC HEALTH NURSES COULD PLAY TO HELP WITH COMMUNITY HEALTH PROBLEMS (N = 68)

ROLE	NUMBER OF RESPONDENTS CITING ROLE	PERCENT OF RESPONDENTS CITING ROLE*
Prevention of Illness	24	35.3
Caring (as Psychosocial Concept)	12	17.6
Direct Care	10	14.7
Referral	5	7.4
Maintenance of People at Home	1	1.5
"Filling in" for Other Care Providers	1	1.5
Specific Services Related to Program	0	0.0
Providing Cost-Effective Service	0	0.0
Other	15	22.1

*These percentages are based on a denominator of 68, the total number of persons responding. Any one respondent could supply multiple responses.

What people did not say was almost as interesting as what they did say. In contrast with nurses themselves, consumers did not mention "programs," and only one respondent mentioned either "filling in" or maintaining people at home. This comparison of nurses' and consumers' views is documented in Table 6.

TABLE 6: COMPARISON OF CONSUMERS' AND NURSES' PERCEPTIONS OF PUBLIC HEALTH NURSING

	CONSUMERS (n = 78)		NURSES (n = 90)	
ROLE	Number	Percent*	Number	Percent**
Direct Care	29	37.2	54	60.0
Prevention of Illness	38	48.7	47	52.2
Specific Services Related to Programs	15	19.2	39	43.3
Maintenance of People at Home	6	7.7	26	28.0
Referral	5	6.4	21	23.3
Caring (as Psychosocial Concept)	27	34.6	20	22.2
"Filling in" for Other Providers	3	3.9	8	8.9
Providing Cost-Effective Care	0	0.0	5	5.6
Other	8	10.3	13	14.4

*These percentages are based on a denominator of 78, the total number of consumers responding. Any one respondent could, and many did, mention multiple roles.

**These percentages are based on a denominator of 90, the total number of nurses responding. Any one respondent could, and many did, mention multiple roles.

Both nurses and their potential clients were aware of the concepts of direct care, preventive care, and a more diffuse caring. It can and should be noted, however, that these roles are ranked differently by the two groups. Consumers do not think in terms of "programs" as do the nurses. It is particularly interesting that the consumer view of public health nursing emphasizes the textbook definition of a nursing role through generalized caring and preventive care more strongly than does the view of the nurses. Nurses see themselves primarily as deliverers of direct care.

In summary, this section describes responses of selected community residents expressing their view of their communities' major health problems and their perceptions of the public health nurse's role in alleviating these problems. In that consumer awareness and acceptance are critical in the planning and delivery of quality nursing services, this consumer perspective is of great importance.

LIMITATIONS

Limitations of the tool as developed became apparent during the course of the project. The need for systematic sampling has been mentioned, if data are to be generalized to a large population. Also, the interview protocol consists primarily of open-ended questions that promote free expression of responses, but such responses can be time-consuming to compile and analyze if large samples are used. Possible bias in relation to selective reporting of socially sensitive health events -- for example, alcohol overuse -- has been discussed. Furthermore, control over field work to assure that questions are asked

in a way that allows for both exploratory, ethnoscience data and for more structured data is essential.

Finally, in relation to the reporting of chronic versus acute conditions, we recommend that in further use of the instrument, clear differentiation should be made between acute and chronic illnesses. The disruptions in daily living and need for specific services differ greatly depending on the acuteness or chronicity of the condition, thus justifying this differentiation.

CONCLUSIONS AND NURSING IMPLICATIONS

The project described in this report demonstrates the feasibility and value of a consumer-oriented nursing needs assessment. This assessment has provided a wealth of valuable information to the nursing profession regarding the health status and attitudes of Wyoming residents. It also provides planning bodies with insights into the role of community nursing services and the need for such services. The tool has a wide range of applications to nursing practice, education, and research. In nursing practice, the nursing needs assessment can help to

1) identify public definitions of health and health-promoting behaviors;

2) pinpoint life-altering events from the consumer perspective as a way to identify high-risk groups for preventive intervention;

3) indicate consumers' knowledge of self-care and/or therapeutic care activities and their perspectives on the roles of professionals and nonprofessionals;

4) identify formal and informal support systems as well as patterns of caring within a community;

5) outline health care patterns;

6) clarify the public view of the public health nurse and of his/her potential usefulness in particular areas of practice;

7) identify community health problems as consumers perceive them;

8) determine the most effective forms of publicity to use in informing consumers of available nursing services;

9) provide concrete data based on consumer reports for defining the scope and determining staffing and funding needs of community nursing programs.

In relation to nursing education, the nursing needs assessment serves to

1) clarify the consumer definition of health as contrasted with contemporary nursing theory. Does the health-promoting philosophy of nursing correlate with public views?

2) realistically prepare nurses to practice, particularly in rural and small communities, by

a) conveying public conceptions of community nursing practice;

b) identifying perceived health problems;

c) indicating formal and informal coping strategies and interventions utilized by community residents;

3) guide curriculum planning so that it remains relevant and sensitive to the dominant health concerns and needs of the community.

Finally, by using the nursing needs assessment as a primary tool in nursing research, the development of nursing science will be enhanced. Concrete identification and description of the uniqueness of professional nursing practice from a consumer-oriented perspective is essential. Such a tool advances the field of nursing research by translating contemporary nursing theory into a sensitive measurement of nursing practice. Such continued research will serve to enhance the planning, implementation, and evaluation of nursing practice and education as well as to expand the body of knowledge in nursing science.

As nursing continues to develop a community orientation with consumer advocacy and health promotion as primary goals, the potential for use of the nursing needs assessment concept will likewise grow. A conceptual tool linking practice, education, and research will serve to strengthen the profession and enhance the quality of health services in the long term.

APPENDIX

PUBLIC HEALTH NURSING STUDY

Protocol

Introduction and Purpose of the Study

Hello, I'm _____ from the University of Wyoming. Faculty at the University have received a grant from the state to conduct a study of public health nursing and public health nursing needs. The purpose of the study is to develop a new procedure for estimating the need for public health nursing staff and services in the counties and communities of Wyoming. The study includes describing current practices, identifying health care problems and needs, and obtaining ideas or suggestions for improving public health nursing services in Wyoming. In addition, we need your help in understanding how people of this community think about health, what they do about it, and what kinds of health-related events interfere in daily activities.

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Interview Procedures

1. The information you provide will be kept confidential and will not be published in such a way as to identify you personally.

2. Your participation is entirely voluntary. You may refuse to answer any question that makes you feel uncomfortable. You may stop the interview at any time.

Do I have your consent to continue? Yes_____ No_____

Signature_____ Date_____

FAMILY DATA

1. Place of interviewee's residence (i.e., in town or outside town)_____

_____

2. How long have you lived here?_____

3. Where did you live prior to moving here? (Give town and state.)_____

4. Please describe who lives at your house. (Use initials, not names of family members.)

INITIALS	SEX	AGE	RELATIONSHIP	EDUCATION (YEARS)	FT/PT	EMPLOYER	JOB

5. Do you have relatives living in this area?_____ How many?_____

_____

_____

Date of Interview_____ Place of Interview_____

Interviewer_____

Community Name_____

1. We're first interested in how people define health. What does a person look like or do that makes you think he or she is healthy?

Would you look for different things in men and women?

- Men

- Women

What about children? Do you look for different things in children?

2. In the past year, what kinds of events have interfered in daily activities of people in your family?

Probe specifically for the following daily activities, i.e., what about problems with:

1. sleeping/resting
2. eating or appetite
3. mobility
4. elimination
5. working, going to school, working around the house
6. participation in social activities
7. contact with or relationship with family and friends
8. pregnancy - pre and post
9. accidental injury
10. crisis - family separation/life change
11. overuse of alcohol
12. illness
13. social isolation
14. continuous low-level anxiety

INITIALS OF FAMILY MEMBER	EVENT INTERFERING	TYPE OF ACTIVITY DISRUPTED - DURATION	WHAT DID S/HE DO ABOUT IT?	WHAT DID OTHER PEOPLE DO ABOUT IT	HOW WAS THE PROBLEM SOLVED?

3. In general, what kinds of events happen to people of this community that interfere in their daily activities?

EVENT	TYPE OF ACTIVITY DISRUPTED	KINDS OF PEOPLE AFFECTED (BY AGE AND SEX OR OCCUPATION, ETC.)	WHAT DO THEY DO ABOUT IT?	WHAT DO OTHER PEOPLE DO ABOUT IT?
(Please record in the words of the respondent.)				

4. Now, we want you to describe the contact with physicians, nurses, and other health care providers or services for each person in the family. Please describe their use of services during the past year. (Here is a card listing health care services.)

WHO	PROVIDER	SPECIALTY	NUMBER OF VISITS/YEAR	NUMBER OF ADMISSIONS, TOTAL DAYS, PROBLEMS, SURGERY, SERVICE, OTHER

80

92

93

5. What are the most important things people in this community do to maintain or promote good health?

6. Have you or anyone in your family ever been in contact with a public health nurse? For what purpose? (If a care situation, probe for impression of quality of care.)

7. What do you think public health nurses should do?

8. What are major health problems in this community?

9. What do you think public health nurses could do to help with these?

10. How many public health nurses do you think this community needs?

11. Are you aware of the following nursing services available in this community? (Use card listing services available in community. Cross out any listed below not available and add any others unique to this community.)

How did you hear about this service?

TYPE OF SERVICE	AWARENESS Yes	No	INFORMATION SOURCE
Immunization clinic			
Pre-natal classes			
Home health services			
Newborn infant			
Crippled children's service			
Well child clinic			
Pap smear screening			
Family planning clinic			
Sickle-cell screening			

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Have you or anyone in your family used any of these services in the past year? (Y) (N) (DK) (NA)

Which services?

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VIEWING HEALTH AND HEALTH NEEDS THROUGH MANY EYES: THE ETHNOGRAPHIC APPROACH

by

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At Montana State University, several research projects are yielding useful and sometimes surprising information about perceptions of health and health care needs in this sparsely populated Western state. For over three years, the graduate program of the School of Nursing, of which I am director, has been conducting research aimed at assessing rural health care needs. In addition, a survey of community leaders in Montana and several master's theses examining minority groups in the state have helped to round out the picture. Some surprising preliminary findings of this research have resulted. Among them:

1) Montanans generally perceive themselves as healthy, even though they may have a chronic disease or disability.

2) Most citizens believe that they have adequate access to health care facilities, even though the distance to hospitals or specialists is often great. Most people organize periodic

trips to the city for other needs and tie in visits to doctors and clinics with those. Mental health facilities, in fact, are sometimes seen as too close, posing a threat to privacy. In contrast, community leaders tend to see a need for more physicians and health care facilities.

3) Alcoholism is a frequently cited health care problem. Others include child abuse, teenage pregnancy, suicide among youth, mental illness, and violence.

4) Coordination between local health care personnel and more distant specialized facilities is seen as poor.

5) Among Montana's minorities, special areas of concern include a high incidence of depression in Hutterite colonies, especially among the women; alcoholism on Indian reservations; and disruption of the family hierarchies of Hmong immigrants.

The graduate program of the Montana State University School of Nursing centers around rural health care, with a research-based focus aimed at developing a theoretical approach to rural nursing. Needs assessment and other data collection form the basis for the program, influencing course content and clinical experience for all graduate students, regardless of specialty area.

Data gathered for this long-term project focus on health and health care in general rather than on any particular aspects of health or illness. Mental health, being one aspect of health that affects all others, is a frequently addressed topic. The first stage of data collection for the graduate program project is not yet completed.

Statistical analysis is preliminary and incomplete, and descriptions of rural populations remain tentative. These impressions have been derived over three years, during which time data were collected from four areas of Montana: the environs of Missoula, Billings, Bozeman, and Great Falls.

An ethnographic approach has been used to elicit specific information about people's perceptions of health. Students learn the basic technique of data collection in class, practice in and out of class, and are supervised by a nurse-anthropologist and a psychiatric nurse. In the first year of the two-year program, students interview subpopulations or cultural groups, families, and individuals as part of their clinical practice. The ethnographic approach provides the investigator, in this case a nurse, with direct information about people's perceptions of their world in their own words, with minimal injection of bias by the investigator. Initiating the study at the descriptive level was deemed essential because of the lack of research-based information on rural health care and rural nursing in the West.

One of our main concerns in establishing the program was the distribution of nurses, physicians, hospitals, and health care facilities in rural areas. Montana State Health Department reports and statistics revealed maldistribution of both nurses and physicians, with about 80 percent of the state's physicians concentrated in six of its fifty-five counties. Both health care facilities and health care professionals were entirely absent from some sparsely populated counties. While some nurses lived in thinly settled areas, few of them were active in nursing (Montana State Bureau of Records and Statistics, 1975).

A review of the literature on rural nursing revealed that little was being reported on the issue and that few nursing programs at that time specifically focused on rural health care. In the fall of 1980, the University of Wyoming began a master's program in rural family health nursing. In addition to gaining skills in advanced rural community nursing, the students are also educated to become family nurse practitioners.

Most rural health projects appeared to be in the East and South. Programs to provide care in Appalachia and the rural South had been initiated in the 70s (Hassinger and Whiting, 1976). For example, the Health Services Research Center of the University of North Carolina and the North Carolina Office of Rural Health Services joined forces in a series of projects which culminated in the Rural Health Center Development Series (Hege, 1979). Differences in the areas and populations served suggested that such programs were developed to meet different needs and health care problems than those existing in the West.

Rural areas in the West tend to be more sparsely populated than are those in the East. Characteristics of populations also differ. Westerners who live in rural areas are not necessarily poorer or less well educated than urban residents. They include farmers, ranchers, miners, forestry and railroad employees, small businessmen, and retired people. The West represents a unique ethnic mix, with Native Americans, both on and off the reservation, Mexican-Americans, and other minorities less commonly found in the East.

In designing the M.S.U. program, we hoped to define Montana's unique needs in order to develop health care programs specifically appropriate to the state. An analogous situation is that of community mental health centers, which had to adopt new approaches not needed in the old state hospitals, moving from individual to group, family, and community-oriented treatment. In rural health care, similarly, there is a need to adapt urban programs in view of the total environmental context -- the characteristics of the population; regional and occupational groups, their distribution and perceptions of their own needs; political and social attitudes; and ethnic variations. Government funding and regulations often do not encourage the flexibility needed to meet such needs.

MONTANA'S DEMOGRAPHY

The United States Bureau of the Census (1975) defines rural areas as nonmetropolitan areas with populations under 50,000. A Standard Metropolitan Statistical Area (S.M.S.A.), as defined by the same document, is a city of 50,000 population with a total population of city and immediate environs exceeding 100,000. According to these definitions, Montana has no large metropolitan areas and no S.M.S.A.s. In fact, it has only two urban centers over 50,000: Great Falls and Billings -- and several smaller cities considered urban by Montana standards because they serve large areas surrounding them.

Montana represents the typically Western range of occupations and ethnic groups described above. There are a number of Indian reservations and a variety of other ethnic groups represented chiefly in the

mining towns. Each, of course, has its own cultural legacy and unique set of health beliefs.

There are many elderly people living in small towns across Montana. They tend to be politically conservative. Western independence is often stressed along with a "boot-strap" philosophy that disdains help. The elderly tend not to want to leave work to go to the doctor. They also tend to be suspicious of government programs, including subsidized health care, despite the fact that there is a long history of subsidized farming and ranching in Montana.

Causes of death in Montana follow the national pattern, but mining areas tend to have a higher incidence of respiratory diseases and malignancies. The incidence of alcoholism is very high, and alcohol-related accidents and illnesses are common occurrences (Montana State Bureau of Records and Statistics, 1975). Respiratory diseases and depression are thought to occur with high frequency among rural Montanans, including farm and ranch families (conversations and interviews with public health nurses).

Do they? Are depressed people turning to alcohol? Is there more mental illness in rural than urban areas? How do people cope with distance from medical centers and access to specialists? How are mental health problems recognized and treated outside of cities, where there is limited access to private psychiatrists? Is drug abuse a problem in rural areas as it is in urban areas? What is the role of nursing in rural health care? What roles can be developed to better meet health needs in sparsely populated areas? These questions and others not previously covered by research were instrumental in forming the

development of M.S.U.'s graduate program in nursing. While the preliminary findings address some of these questions, many remain to be answered.

In summary, the M.S.U. program has been designed to obtain:

1) knowledge of needs as clients perceive them;

2) knowledge of needs as caretakers perceive them;

3) knowledge of the environment in which care is needed, sought, and provided; and

4) understanding of the sociocultural context of care, the culture in which people's health and illness beliefs are embedded.

THE M.S.U. PROGRAM

The M.S.U. graduate program in nursing is a two-year master's degree program developed to utilize all five campuses of the School of Nursing: the main campus at Bozeman and extended campuses in Billings, Butte, Great Falls, and Missoula. Rotation to different campuses makes the program accessible to nurses unable to move or commute to other parts of the state and provides the opportunity for broad-based data collection. The program is funded by a U.S. Public Health Service training grant.

Specialty-area courses in the second year are available in community health, maternal-child nursing, and medical-surgical nursing. A separate N.I.M.H. Psychiatric Nursing Education Branch grant has supported the preparation of psychiatric/community mental health

nurses. The graduate of this program is referred to as a mid-level clinical specialist. Preparation includes advanced clinical practice with seriously ill patients as well as participation in teaching, administration or consultation, and some aspects of the organization and delivery of health care. Experience emphasizes both rural and urban settings.

Plans to collect data on rural health care and health needs of rural populations were projected for five years. After rotation to Missoula, Billings, and Great Falls, the program returned to Missoula for the 1981-82 academic year, with plans for rotation to Butte the following year. During the first year of program rotation, students participated in a health needs assessment under the auspices of the Five Valley Rural Health Initiative, which covered a three-county area -- Missoula, Ravalli, and Mineral counties. Students administered a health needs assessment questionnaire, kept field notes, and recorded contacts with individuals, interviews, and other responses not included in the formal survey. These field notes were a rich source of data, although they varied considerably from student to student. Due to problems in working with another agency with different goals, faculty decided after the first quarter to concentrate on descriptive studies and abandoned the questionnaire. Ethnographic data collection became the vehicle for a series of assignments throughout the two-year program. During the first year of the program, the emphasis is on learning how rural people view their health needs, how they perceive access to care, what kind of support systems they use, what kind of help they seek, and what resources exist in rural areas. During the

second year, students focus more specifically on research while preparing their theses.

Student assignments in the first-year courses are coordinated. For example, the same community may be the focus of a community study, an investigation of a particular subculture's health needs, an outline of health care systems and their linkages to larger communities, and an intensive examination of health care in a particular family. Small-hospital surveys are also done in the communities that have such facilities.

The additional work done by many second-year graduate nursing students, both in clinical assignments and in theses, has provided further data. Extensions of data collection into the second year relate to specialty-oriented problems, such as how home dialysis patients help each other.

There has been systematic feedback into the program each quarter as students gain knowledge of local and regional health care needs and report their findings in seminars. Some changes have been made in course content as a result. The process of ethnographic data collection will continue with the gradual addition of more refined tools to collect quantifiable data.

THE ETHNOGRAPHIC APPROACH

Before looking at the findings, a word needs to be said about the tools our study has used. The ethnographic approach is a method of data collection used in anthropology which acknowledges limitations of the observer in understanding the behavior and social rules of another

culture or subculture. The emphasis of anthropological studies has traditionally been on participant observation and description, with diligent attention to keeping field notes. In the 60s and 70s, such techniques were refined, with greater use of systematic questioning and attention to linguistic issues (Frake, 1964; Goodenough, 1970; Tyler, 1969). Spradley (1979) has provided an excellent guide for teaching students to interview strangers with minimal bias.

Our study attempts to describe culture as much in the terms of the people themselves as possible. Observers must be aware that even within American society, many practices will appear strange or alien and that researchers must be careful to keep their own biases out.

In our study, subjects are asked to describe what they are doing in their own words and to define their terms. Tape recorders are often used with additional written field notes compiled for description, clarification, and recording of impressions. Repeated observation and questioning are required. Terms, definitions, and interpretations are checked with key informants (other members of the population).

Selection of a key informant is a process which is initiated on entry into a new community or subculture. A key informant validates data collected from other informants. Details of the subject being investigated may be missed in other interviews but can be supplied by a key informant with whom the ethnographer has established rapport. Terms, definitions, and interpretations are cross-checked. A range of meanings emerges from this process which approaches the complex dimensions of the culture. Care must be taken in selection of a key informant that certain criteria are met: centrality in the group,

knowledge of many aspects of the culture, ability to communicate, and personal characteristics which enhance communication with the ethnographer. A good key informant in a rural area is often the postmaster or mistress. Spradley (1979) provides a good discussion of considerations and problems involved in the selection of key informants.

In an ethnography, it is preferable for the observer to enter the situation as a stranger. It is easier to be biased in situations where people are known beforehand. For example, when students practice ethnographic interviewing on family and friends, they often anticipate responses, omit questions, and feel silly about asking some things. Their prior knowledge distorts the interview situation. A stranger may elaborate on and discuss questions which familiars would not respond to in the same way (Spradley, 1979).

THE INTERVIEW

Ethnographic interviewing requires preparation. Graduate students practice classroom interviews and seek out individuals they do not know well for further practice outside of class. The interviewer's opening statement is especially important. Since there is no such thing as an unbiased interview, it is critical to consider what to present first and how to say it.

Introductions must be consistent. They convey crucial information about oneself and the purpose of the study. Our graduate students develop introductions they are comfortable with, such as: "I am a

nurse. As a nurse, I want to know how people perceive health and health problems -- it will help me in planning care."

The interviewing then proceeds with the questions. The initial inquiry must also be carefully phrased. For example, "Could you give me your definition of health?" The follow-up question requests elaboration: "What does health mean to you?" Further questions may request further refinement: "Would you explain what you mean by 'feeling good'?" "What do you mean by 'having a good attitude'?" "How do you define 'mental well-being'?" A good example of this approach is provided in Bush, Ullom, and Osborne (1975).

Even if the interview is tape-recorded, it is necessary to make some notes at the time or immediately afterwards, describing expressions, body attitude, and the context or situation. Interviews requesting information about people's health perceptions usually take an hour but can take longer.

The interviewer may return to a key informant periodically throughout the interview period. He or she should know many people in the community or subculture and be a source of referrals and assistance with locating people.

Most students make at least five or six trips to an outlying community and interview eight to fifteen individuals. That is usually a large enough sample in a sparsely populated area that uniformities among group members and differences between groups become apparent.

On completion of interviews during the fall quarter, graduate students write a paper describing the group under study and analyzing their responses. Further questions often arise related to health practices of a family or a segment of the population. These may be followed up intensively the following quarter, when the focus is on health assessment of rural families.

These papers, which describe, enumerate, and analyze health perceptions of groups of people, have been a valuable source of data for both faculty and students. The time-consuming process of analysis and interpretation of all the information is only the beginning, with content analysis as the first step. Interpretation of the findings (papers on health perceptions of sparsely populated areas) will proceed simultaneously with development of survey and hypothesis-testing tools.

THE FINDINGS

Graduate students found that most people were willing to talk about their own health. Informants often brought up someone they knew who had poor health as a contrast to their own situation. People generally saw themselves as healthy, and most commented on the importance of good health.

People generally felt healthy or perceive themselves as healthy even though they may have had a chronic disease or disability. Many of the informants defined health in mental rather than physical terms, as having a positive attitude or outlook, feeling good about themselves. Some elderly people spoke in terms of still being able to get around,

of still being able to care for themselves, or of being better off than others.

Perceptions of access to care and of distance to specialists or specialized care facilities were not as expected. Most people believed they had adequate access to care and were not too distant from hospitals and physician specialists. Snyder (1979) found in a study of kidney dialysis patients in Montana that distance from the home dialysis center was not seen as a problem. Patients developed their own support network for immediate needs such as dialysis solution and spare parts for their machines. With their emergency needs taken care of, the dialysis center, which was usually in another state, did not seem too distant. Some rural people said they would like to have health care facilities nearby, but most people planned their trips to the doctor, hospital, or clinic to coincide with regular trips into the city where they bought groceries, clothing, and other requirements. Even elderly people who were dependent on others for transportation said they perceived care as accessible.

The only mental health problem which was brought up repeatedly was alcoholism. People from all of the areas of Montana surveyed saw alcoholism as a major health problem. Some talked about the number of bars in the small towns they lived in, others about people they knew who overindulged.

Project 80, a recent study completed by M.S.U. Cooperative Extension Services (1980) asked community leaders in all of Montana's fifty-five counties to assess changes which have occurred in the last

twenty-five years; to identify problems and opportunities at local, district, and state levels in relation to problems of contemporary life; and to determine ways to make Montana a better place in which to live. Many of the problems identified in this survey were related to mental health.

Disruption of the family was a major subject of concern to Montanans. Changed work patterns were cited -- notably wives and mothers working away from home -- as was extensive use of television, especially by children, resulting in families' spending less time together. These disruptions of family patterns were seen to interfere with the transmission of moral and spiritual values. Families' needs identified included preparation for family life, such as pre- and postmarital courses in parenting. Ongoing education for families to help them teach moral values, provide sex education, and generally improve communication among family members was also identified as a need. The study recommended that families need to be informed about alcohol use and abuse; that to prevent mental health problems, parents need assistance in learning how to improve the self-images of their children; and that programs in stress management need to be made available through mental health agencies.

Other problems identified in Project 80 as well as in ethnographic interviews and state health statistics include child abuse, teenage pregnancy, suicide among youth, mental illness, and violence. Incest and gambling, not discussed in the ethnographic study, were both identified in the Project 80 survey.

Despite Montana citizens' apparent complacency about distances to health services, community leaders interviewed by Project 80 wanted more physicians and health care facilities available locally.

One major problem agreed upon by studies and supported by the literature (Hassinger and Whiting, 1976; Roemer, 1976) is the lack of coordination of services in rural areas. There is poor feedback to local physicians, clinics, and public health nurses regarding transfers and community reentry for patients who have received specialized care at a distant facility. There is little communication with those who have provided emergency care and stabilization for transport. If these problems are great in relation to physical care, they must be paralleled in mental health care. The individual's right to privacy creates some tension between provisions for adequate care and adequate protection of families and community members.

Another specific mental health problem should be mentioned, as it is common in rural Montana and probably in other areas. The placement of mental health centers in small towns takes place without consideration of residents' need for privacy. In interviews in a number of areas of Montana, individuals expressed their dismay at the fact that a mental health center had been located in the center of town, where all the townspeople could monitor the arrival and departure of clients. Many people said they would never go to the local mental health center or take a member of their family there. If their need for mental health care were great enough, they would go out of town, preferably to a large city, where privacy would be insured.

MONTANA MINORITIES

Cultural groups who differ from the dominant society in ethnic or religious background and way of life are often misunderstood by health personnel and others. M.S.U. student and faculty studies of three different Montana groups illustrate some of the problems which may be intrinsic to the culture or precipitated by interaction between cultural groups.

There are several Hutterite colonies located in Montana's agricultural areas east of the Rocky Mountains. A study of child-rearing practices (Hickey, 1980) revealed that discipline is very strict, children are dealt with consistently, and their behavior is expected to be controlled from early in childhood. Children learn early in life that their needs are secondary to those of the colony. The very strict conformity required of colony residents may be a factor in the prevalence of depression among the Hutterites and especially among women. Hutterite women have less freedom than the men. Does the dominant male role and preference for male children devalue women and function as a factor in depression? Or is the concern over subordinate roles of women a cultural bias of Anglo-Americans? Can depression among Hutterites be traced to endogenous factors? Even if endogenous factors can be established, can contributory environmental factors be isolated? What happens to Hutterites who leave the colony? These questions, raised by Hickey, remain to be answered.

Native Americans, like other visible ethnic groups, encounter many situations in growing up which promote low self-esteem and feelings of lack of control over their own life situations. Indian hospitals and

health programs have not generally recognized the enduring values and traditions of the Native American tribal groups. A study of the health beliefs of pregnant Crow women was done to learn what practices could be recognized and accommodated by hospital and health caretakers during prenatal care, labor, and delivery (Harding, 1981). This study represents a small step toward defining and alleviating the health care problems which are exacerbated by discrimination and poor communication.

Alcohol abuse is a factor in many accidents leading to death or serious injury, suicide, and homicide among Indian groups. The roots of this problem, as with depression among Hutterites, must be examined in their cultural context. For example, what aspects of culture contribute to homicide and suicide in urban Indian groups as compared to those who live on the reservation? How many Native American one-person automobile accidents are actually suicides? If more meaningful jobs were available, would the suicide and homicide rates be decreased?

A large group of Hmong refugees has moved to western Montana as part of the influx of Southeast Asian refugees over the last five years, and a study of their health and acculturation is now in progress (Taylor, 1982). Requirements of health and hospital personnel are sometimes antithetical to the beliefs of the Hmong people. For example, according to the Hmong, women are not supposed to drink ice water or ingest any cold food during labor and delivery and for a period after the birth of a baby. Chicken soup is considered to be the most desirable food for the new mother. Because of the language barrier and other communication problems, hospital staff do not

understand such cultural requirements and are often angry and frustrated by Hmong women's refusal of food and water during childbirth.

Depression is also a problem among these people. Having to learn to speak English under the immediate pressures of needing employment is frustrating and discouraging for many of them. They want jobs and are accustomed to working from dawn to dusk, seven days a week, except for a three-day holiday at New Year. The family is very important to the Hmong, and elders are respected. Now the elders are having more difficulty with English than their children, and the discrepancy is interfering with customs related to respect. The war and immigration in themselves have undermined the traditional Hmong family. Taken together, these factors combine to produce great stress and directly threaten the health of those who do not speak English and do not have job skills. Most of these people are very worried about how they will continue to provide for their large families.

SUMMARY

A five-year survey of health care needs in rural Montana and related research are revealing interesting and sometimes unexpected information about how Montanans view their own health and medical treatment. Data collection is still going on, and findings are only preliminary. Initial findings are less bleak than might be expected for this often isolated population. People tend to see themselves as healthy even when they suffer from diseases or disabilities, and distance from health care facilities is not generally perceived as a problem. It is hoped that the research will lead to design of health

care programs addressed specifically to the unique needs of the state. Similar ethnographic surveys in other rural areas would yield fascinating sources of comparison and contrast.

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TRAINING HUMAN SERVICE WORKERS FOR PRACTICE IN BOOM TOWNS AND OTHER CHANGING RURAL COMMUNITIES

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During the 1970s, rural communities in all regions of the United States experienced the beginnings of a population turnaround (Beale, 1975; 1977). Migration to nonmetropolitan areas altered the patterns of population stability or decline which characterised small towns and rural communities during the previous decade. During the 80s, multiple sources of rapid growth confront small rural communities, including population migration from metropolitan areas, energy development, rural industrialization, and recreation area or resort development.

Portions of this paper are adapted from material originally appearing in Morris, J. H., and Morris, L. C., 1981, Meeting Educational Needs in Rural Communities Confronting Rapid Growth. Las Cruces, New Mexico: Educational Resources Information Center (ERIC) Clearinghouse on Rural Education and Small Schools (CRESS).

In many communities the turnaround has been associated with hopes for a rural renaissance and a small town revitalization (Morrison and Wheeler, 1976). Experience, however, has indicated a far more complex impact involving multiple and often unanticipated changes -- both benefits and problems -- accompanying rapid population and economic growth.

How much growth and change are required to create problems of personal, social, cultural, and institutional adjustment in small communities? A study of energy-impacted communities in Wyoming indicates that an annual population growth rate of 10 percent a year places a strain on a small community's capacity to provide services to its residents, and a growth rate of 15 percent a year causes serious breakdowns in service-providing capabilities of both local and regional institutions (Denver Research Institute, 1974). A rate of population growth exceeding 10 percent per year is typically considered the point at which providing services and adapting to change become a problem in small communities.

In many areas of the United States, growth rates far in excess of this 10-percent-a-year threshold have been reported. For communities adjacent to energy development projects, population growth often exceeds 25 percent a year (Gilmore, 1976). Extreme examples of the scope of rapid growth confronting small communities include Craig, Colorado, whose population grew 200 percent in seven years (Cortese and Jones, 1977) and Rio Blanco and Garfield counties in Colorado, where development of proposed oil shale plants could produce a population increase from the current 75,000 to 1,500,000 residents (Kelly, 1980). In

addition, where much of the population growth results from the "boom" construction phase of energy or industrial development, an equally rapid period of population and economic decline, or "bust," can be anticipated to follow the period of rapid growth.

Although energy-impacted communities represent an extreme of rapid growth, a population turnaround has occurred in rural communities throughout the United States. Regions with rural counties experiencing the highest rates of population growth during the period 1970-75 included the Southwest, the Intermountain West, the Far West, parts of Florida, the upper Great Lakes, central Texas, and the Ozarks (Ross and Green, 1979). The 1980 census indicates even more widespread population growth in rural communities. Analysis of 1980 census data indicates that during the period 1970-80, the population of nonmetropolitan counties increased by 15.4 percent. Every state except Rhode Island experienced nonmetropolitan population growth during the 1970s, the most rapid increases occurring in the West. Portions of rural Wyoming, Colorado, Arizona, Nevada, and California grew by more than 50 percent (Beale, 1981). Although economic factors account for population growth in some communities, influences such as the search for an improved quality of life are also associated with such migration (Ploch, 1978; DeJong and Humphrey, 1976).

PREPARING FOR CHANGE

Preparing human service workers for effective practice in boom communities requires an understanding of the particular social and economic features of this setting. The boom, or frequently boom-bust, process is rapid and disturbs complex and intricate patterns of living

which have sustained community life in the past. The process involves more than changes in size (getting bigger fast), changes in social and cultural relationships (getting citified fast), changes in economic organization (getting richer and poorer fast), and changes in the organization of public services (getting formal fast). Rather, as Cortese and Jones (1977) have noted, what happens in boom towns can be understood as the product of interaction between the old and the new in any particular community.

Ideally, small communities and rural areas can build upon their social and cultural heritages in coping with the impacts of rapid growth. In contrast, severe stress will result if traditional social and cultural supports are weakened and not rebuilt. Rural areas are characterized by rich community and cultural diversity which suggests the potential for a variety of responses to externally induced change and the strength to seek alternatives which preserve community dignity and identity. Change does not have to involve being changed by, being shaped by, or taking on the characteristics of the large-scale, impersonal, absent forces -- such as corporations or federal bureaucracies -- which are making decisions that influence community development. Passive, fatalistic attitudes to change, which quickly become self-fulfilling prophecies, are a recurring problem in boom communities (Moen, 1980).

Any training for practice in rural areas requires the learning of special skills. Preparation for effective practice in boom communities requires the ability to work with community residents in planning services, the vision to anticipate consequences of planning, and the

wisdom to make decisions that will minimize the negative impacts of change and direct new resources acquired from economic growth into human and community development. Such practice requires a high level of community involvement and an ability to mobilize people and resources to deal with the stresses of change, skills similar to those required for effective crisis intervention. Reactions to rapid growth may include alienation, grief, and general dissatisfaction with life's circumstances. A new balance of strains and gains emerges for different groups within the community. New sets of social inequalities and opportunities may develop. Job opportunities may open up for younger residents, for example, while rising prices increase economic hardships for older residents. Such differential costs and benefits of change can increase the difficulty of building an effective community planning process.

Educating health and human service workers for practice in a boom community requires development of skills in assessment of complex and fluid situations, in building and sustaining a community planning process during which the statuses and networks of the participants may undergo considerable change, and in careful evaluation of the multiple impacts of proposed "solutions." One of the most crucial aspects of such work is in assessment. This activity includes not only the gathering of accurate factual information, but also a dynamic, interactive process which involves the worker with many different members of the community. Through the process of assessment and planning for change, residents must build new ways of working together while simultaneously experiencing a decline in the shared routines of living which connected them in the past. Network building and maintenance develop as a

counterforce to the pressures of economic self-interest. The undermining of networks and support systems has been identified as a primary contributor to increased stress and decline in coping abilities of boom community residents (Gold, 1979a).

Establishing an assessment and planning process can be extremely difficult in rural communities experiencing rapid growth (Bleiker, 1980). The complexity of changes that accompany rapid growth has given rise to the newly emerging field of social impact assessment, but many needs may not be anticipated by a particular local community.

Establishing an effective process for community participation and decision making can also be difficult. Problems include fatalistic attitudes (Moen, 1980) and oldtimer-newcomer conflicts (Graber, 1974). Distorted information and the absence of information can lead to loss of trust and severe disruption of established networks of communication and support. New types of community and regional planning networks are emerging, however (Gold, 1979b; Gerlach, 1976; Bradshaw and Blakely, 1979).

ASSESSING CHANGES IN SERVICE NEEDS AND DELIVERY

Health and human services are impacted by rapid growth both directly, through changes in the size and composition of the population, and indirectly, through community changes which create new needs for a variety of groups and alter community expectations.

Questions for health and human services planners to address include:

1) What types of information can be used to predict the anticipated needs of the population? Information concerning both the size and composition of newcomer families must be obtained. Experiences of communities confronting similar growth are valuable sources of data. In general, rapid growth associated with population migration from metropolitan areas involves newcomer families over age 25, many of whom have school-aged children (Tucker, 1976) and older persons retiring to rural areas (Beale and Fuguitt, 1976). When newcomers are part of a construction work force, estimates become more difficult. Families may or may not accompany incoming workers. The size of the arriving work force may itself be difficult to predict, because jobs may or may not be filled by local residents.

2) What is the estimated time frame for growth? One of the first and most difficult tasks in the planning process is to specify the time frame during which rapid growth, or a cycle of growth and decline, is expected to occur. If a boom-bust process is anticipated, planning must include arrangements for both service expansion and eventual reduction.

3) Are there ways to lessen the impact of a rapid increase in population? Possible strategies for reducing negative impacts include hiring as many local residents as possible for rural industrialization and energy development and spreading out the time period over which rapid growth will occur.

4) What will be the rate of turnover in the population? A common problem in areas confronting rapid growth is the high rate of mobility of the new population.

5) How will the socioeconomic and cultural character of the community change? Increased diversity has had a positive impact in many rural communities. If tendencies toward newcomer-oldtimer conflict are overcome, benefits of growth can include expansion of cultural and recreational activities to meet the needs and interests of a more diverse population. Health and social needs and beliefs of new cultural groups must be understood and respected in planning services.

6) What financial support will be needed in planning services? Health and human services facilities may be faced with needs for new construction, new and diversified staff, and expanded outreach programs. Planners may face limitations such as a ceiling on bonded indebtedness or resistance to passage of bond issues -- a particular problem in areas where communities are not equally affected by rapid growth impacts -- and may have to obtain financial assistance through state legislation, private corporations, and federal government agencies.

COMMUNITY PROBLEMS CREATED BY GROWTH

Davenport and Davenport (1979) and Morris and Morris (1980) have noted that a new balance of strains and gains, or costs and benefits, is introduced into a rapidly growing rural community. These costs and benefits will be different for various groups and institutions. The

most vulnerable groups will be those with the least to gain and the most to lose as a consequence of rapid growth and the fewest resources for dealing with the stress and change associated with rapid growth.

A typology of major impacts of rapid growth identified by researchers and the consequences of these impacts for health and human services are presented in Table 1. As noted in the table, increased people problems are usually found in rural communities experiencing a combination of population growth and rapid economic development, such as recreation or energy-impacted communities. The other three impacts -- superinflation, increased service demands, and cultural and social change -- have been reported for growing rural communities with or without rapid economic development.

TABLE 1

Major Impacts of Rapid Growth and Their Effects on Health and Human Services

Types of Major Impacts in Rapid Growth Communities*	Effects of Major Impacts on the Health and Human Services System
Superinflation	Taxpayer revolts resulting in defeat of bond issues. Housing shortages make recruitment of new personnel difficult. Staff seek higher-paying employment, which results in staff turnover.
Service demands exceed service capacities	Health and social services become overstretched, underfunded.
Increased people problems associated with rapid change**	Burnout of professional staff. Increased family problems -- lack of adequate parenting, child abuse. Increased alcohol and substance abuse. Increased juvenile delinquency.
Major changes in community culture and social structure	Replacement of local leadership. Oldtimer-newcomer bifurcation.

*This portion of the table is adapted from J. Davenport III and J. A. Davenport, eds., 1980, The Boom Town: Problems and Promises in the Energy Vortex. Laramie, Wyoming: University of Wyoming.

**Impacts associated primarily with a combination of population and economic growth.

Superinflation

A dramatic rise in prices -- superinflation -- occurs when demand increases for a limited supply of commodities, such as housing. This economic change may have a number of consequences. Taxpayer revolts may occur as residents struggle to cope with rising costs. Housing shortages are common and may make recruitment of new workers difficult. Often human services staff seek new, higher-paying employment in the area. High turnover may result.

Service Demands Exceed Capacities

The situation of service demands exceeding service capacities results from both rapid increase in population and changing expectations within the community. Local administrative and elected officials have noted that community residents coping with rapid growth become more demanding of local services. Problems which before were handled informally now are turned over to service agencies. Administrators and elected officials are expected to "deal with the crisis."

People Problems

Rapid growth brings an increase in problems, such as suicide, family violence, divorce or desertion, and alcohol and substance abuse (Kohrs, 1974). High levels of stress have been reported in a study of rapid growth communities (Welsz, 1979) and are associated with the need for mental health services (Holmes and Rahe, 1967). A grief reaction to rapid change, expressed by statements such as "Everything I've known all my life is gone," may accentuate coping difficulties.

Isolation of newcomers also contributes to the increase in people problems. Because of housing shortages or a community's inclination to confine newcomers to a particular area, new housing developments may consist of mobile home parks on the outskirts of town. Families may be crowded together with few opportunities for social or recreational activities. Increases in family difficulties are encountered when both parents work, often during evening hours, and adequate child care is not available.

While such problems increase in rapid growth communities, the ability of informal support systems and public services to deal with them may decline simultaneously. Many problems can no longer be handled on an informal basis. As social services become overloaded, staff burnout and high rates of turnover may occur. Dixon (1978) has noted the phenomenon of "compassion fatigue" among ministers in her study of the trans-Alaska pipeline impacts. Decline in the ability of informal support systems to handle problems related to alcohol and substance abuse also has been reported (Lantz and McKeown, 1979; Lantz, Sackett, and Halpern, 1980).

Changes in Social Structure

Major changes in cultural and social systems accompany rapid growth in small rural communities. Residents' sense of these changes is expressed in statements such as "Our way of life is disappearing" or "I used to know everyone I saw on the streets. Now when I go into town there is hardly anyone I know."

Newcomer-Oldtimer Interaction

As large numbers of people move into established rural communities with a history of cultural stability and little or no population growth, a we-they split may occur between oldtimers and newcomers. Observers commonly refer to this cleavage as "boom town bifurcation" (Davenport and Davenport, 1980; Massey and Lewis, 1979). Differences in newcomer and oldtimer perspectives which can become a source of bifurcation have been identified by Morris and Morris (1980) and are summarized in Table 2. Additional cleavages may occur when newcomer and oldtimer populations differ substantially in terms of age, income level, cultural background, and language.

Oldtimer and newcomer differences in perspectives often influence the demands placed upon health and social services. One consequence of the we-they split has been the taxpayer revolt, in which oldtimers refuse to underwrite services for newer residents. Conflicts concerning equity in taxation and local political representation may be accentuated when a portion of a county is experiencing rapid growth while other parts are not.

Newcomers and oldtimers may have different expectations of community leaders. Newcomers may expect an administrative style emphasizing rational decision making, efficiency, and professional knowledge. Oldtimers may expect decision making based on personal responsiveness to their needs and concerns. Both groups may make greater demands on leaders to respond to community needs. Turnover sometimes as high as 100 percent of persons occupying leadership positions and replacement

TABLE 2

Comparison of Newcomer and Oldtimer Perspectives in Rural Communities Confronting Issues of Rapid Growth

Community Issues	Newcomer Perspectives	Oldtimer Perspectives
Structure of Social Services	The community lacks social and health services by comparison with urban areas. There is a need for professional services.	Local residents are used to doing for themselves, relying on mutual aid relationships with friends and neighbors. I do not want to give up helping networks and replace them entirely with outside professionals.
School Financing	Schools are overcrowded, may have to go on double shifts.	Rising taxes are a concern for persons with fixed incomes. We would vote down a school levy.
Community Leadership	New leadership is needed in the community. Oldtimer community leaders are insensitive to concerns of newcomers.	Community leaders are old friends who understand my concerns and whom I like and trust. I resent newcomers trying to push them out.
Pace of Life	We are used to faster pace. Community seems to be dragging its feet, not making decisions fast enough. Community resists change.	We are used to slower pace, feel unable to cope with rapid change. Newcomers are impatient. They want everything "right now."
Rising Prices	Newcomers are being short-changed. We get overpriced housing, food, and clothing.	Oldtimers are being short-changed. We get rising prices and taxes.
Isolation	We feel isolated from community life. Community networks, clubs, and churches are closed to outsiders. We feel that we don't know anyone. Community lacks social and recreational activities.	We feel the need to hang on to some established institutions, keep them off limits to outsiders. We feel isolated. Used to know everyone's name. Now town is full of strangers.
Business	The town needs to modernize stores, have variety and quality of merchandise. Need more efficient service.	We want to keep friendly, informal atmosphere of downtown stores which serve as gathering places for residents.
Community Membership	Newcomers are here because of job opportunities or wanting to live a different kind of life. I'm not sure if I will stay, settle down in community. I feel used by community, which wanted us to come in order to have growth but doesn't really want us to be part of the community. Oldtimers want us to leave.	This is my home. I don't want to leave. I have helped to create this community and don't want the things I have helped to build to be lost. Newcomers downgrade local people and practices. They will leave when a better job comes along.

of local leaders with outside professionals have been reported in rapid growth communities (Cortese and Jones, 1977).

While oldtimer-newcomer differences in expectations can become a source of community conflict, positive outcomes have resulted (Ploch, 1978). Newcomers can and do provide new ideas and community support.

Changes in Youth Culture

A change in social structure associated with communities' experiencing both population and economic growth is the increased assumption of adult work and family responsibilities by teenagers. Energy construction firms, community services, and businesses may seek to employ teenagers, often in positions of supervisory-level responsibility. Thus integrated into the economy of the boom town, teenagers participate in a cash-flow economy involving rapid exchange of large amounts of money. If both parents work at jobs requiring evening shifts and long-distance commuting, teenagers often must assume substantial family responsibilities.

This change in teenage roles has several impacts. School dropout rates may increase as students find high-paying employment. Since teenagers are taking on more adult roles within the family and community economy, they often expect to assume more responsibility for planning and decision making within the community.

Dixon (1978), in her study of the Alaskan oil pipeline, noted the problem of a "rip-off mentality" among community teenagers, whose values had become totally materialistic. Although not unique to rapid growth communities, the problem seems to be accentuated by the rapid

accumulation and exchange of money in such settings. Consequences can include increased juvenile delinquency, rising dropout rates, and a devaluing of education as against money-earning opportunities for community youth. Offsetting this impact is the fact that part-time employment provides many teenagers with valuable work experience and an opportunity to save for a college education, marriage, and living on their own.

INTERAGENCY NETWORKING

Coping with rapid growth requires the maintenance of an effective network of interagency relationships. Such networks provide a structure through which human services agencies can exchange information and share scarce resources (Sarason et al., 1977). Informal contacts among human services providers are a common feature of life in rural communities. Under conditions of rapid growth, however, such contacts may undergo change in both structure and function.

Ideally, prior to the impact of rapid growth, a community planning coalition or resource council should be formed (Jirovec, 1979). Participation by organizations such as schools, social services, mental health services, churches, recreation departments, police, and health services can identify potential needs and build working relationships. If rapid growth has already occurred, the joint undertaking of a human services needs assessment may be an appropriate strategy for initiating interagency planning. Agency staff might begin the network-building process by meeting together to discuss common problems such as outreach to newcomer families and staff turnover.

The network should be well organized and task specific but should not be the property or responsibility of any one social service organization. Before it can be effective, all of its members must acknowledge that each member has an expertise to contribute in a unique service area. The agency network should meet once a month, or more if the situation requires, so as to stay on top of the transition and to function as a planning unit rather than in an atmosphere of crisis reaction. The key to network success is to consider community changes as a whole rather than concentrating on specific cases which all the agencies have in common. Individual problems can be solved as examples for service development and delivery.

Fictional composite case histories might be used to develop model responses based on interagency cooperation. These cases could be developed using oldtimers as well as newcomers, single-parent families, low-income families, and minority families. The community transition network could also ask for guest speakers such as members of communities already affected by rapid growth and development, industrial developers, politicians, and representatives from state and federal regulatory agencies and funding sources.

Activities of Interagency Networks

Activities which might be undertaken by interagency networks include:

1) interagency training sessions orienting new staff to community needs and services. This function is particularly important,

since most agencies will experience staff expansion and turnover;

2) ongoing staff development and training sessions to provide support and to combat the common problem of burnout.

3) development and ongoing evaluation of interagency agreements to provide referral and emergency services;

4) interagency training for clerical staff, whose responsibilities may expand to include more emphasis on paperwork, information giving, referral, and empathic responses to service requests under conditions of stress.

Agencies can unite in support of adequate community services needed to cope with the social and human consequences of rapid growth. Interagency networks can point out common problems which affect their ability to recruit and retain staff, such as lack of available and affordable housing. A number of interagency activities can be undertaken to reduce community bifurcation. These may include:

1) development of a community services directory and newcomer's survival kit which provide information concerning helping resources;

2) team outreach to newcomer families;

3) utilization rather than inadvertent displacement of existing community resources, support systems, natural helpers, and volunteer groups;

4) encouraging community residents to take over some responsibility for maintaining services. Persons who have participated in parenting and family living-skills groups, for example, can plan and publicize additional groups;

5) encouraging communication and discussion of community concerns through articles in local newspapers or through a newsletter focused specifically on impacts of rapid growth. Unfounded rumors and lack of accurate information can break down the informal networks of trust and support which have held a rural community together (Gold, 1979a).

USING SIMULATIONS TO PREPARE FOR PRACTICE IN BOOM TOWNS

Practice in growing rural areas requires the development of skills for assessing change from different and more holistic perspectives, for trying out the effectiveness of new types of network structures, for thinking through and vicariously experiencing the consequences of proposed changes. Simulations are learning activities well suited to enhancing these skills. Participants can assume different roles and adopt various perspectives. The consequences of interventions can be evaluated in a no-risk situation. Formation of new types of network structures is easily encouraged.

The need for a more holistic perception of the multiple changes incurred during rapid growth has been pointed out repeatedly by professional observers and boom town residents. Multiple impacts, changes in quality of life, and sense of loss may not be anticipated. Even obtaining accurate information concerning the extent of growth may be

difficult. Simulations of the boom town experience can build in many of these previously unanticipated consequences.

Simulations are compatible with models of human services practice which stress self-help. Simulations encourage problem solving, with problems selected, defined, and often redefined by participants themselves. Solutions are not imposed from the outside. Participants can be encouraged to articulate their own preferences, mobilize their own resources, strengthen working relationships within the boom community, take on new leadership roles, and acknowledge the leadership contributions of others. New skills can be tried out in a low-risk environment.

Accounts of the boom town experience continue to remind us that rapid economic growth can be associated with differential costs and benefits for community residents and can, in fact, lead to greater economic and social inequality. Simulations can be used to focus on how the impacts of change affect people differently and how these impacts can be altered. Outcomes are not fixed but vary with skills and interests of participants. Redesign and adaptation to particular local situations are easily encouraged. The following set of simulations developed to enhance skills for boom town practice incorporates a format for the sequential use of experiential learning tools developed by Glenn (1979). The format involves a three-phase learning sequence including 1) a preinstructional phase emphasizing new subject matter, examining motivation, and raising questions; 2) an instructional phase emphasizing both knowledge-skill development and value analysis; and 3) a postinstructional phase emphasizing application.

The multiple changes associated with community boom can be broken down into three categories: physical changes, changes in social stucture, and changes in cultural values. Before beginning the simulations, participants may use other activities to familiarize themselves with the processes of change. Physical changes can be estimated through models, multimedia presentations, and computer simulations which focus on the quantitative aspects of growth and development.

To measure social and cultural changes, participants may visit a boom community similar to one which they live in, work in, or are studying. Visitors can be paired with comparable residents, for example, social worker to social worker, nurse to nurse. Host residents can provide potential role models for managing or failing to manage change effectively and can give first-hand accounts of the comprehensiveness and complexities of change.

Frequently, a boom is seen primarily as a money-making opportunity. This mind set is often replaced by disillusionment and withdrawal from community life when hoped-for economic advantages do not materialize. Students of change need to raise sophisticated questions:

1) How can the economic resources of the boom be reinvested in the development of the community? The boom community may need to set its own economic development objectives. Otherwise, the economic outcome will be some profit for a small minority with most of the wealth flowing out of the community, untapped and untaxed.

2) What differential costs and benefits will occur to different segments of the community, and how can these costs and benefits be more justly distributed? Women, minorities, and elderly residents, for example, may experience rising prices but not enhanced job opportunities.

3) How can community value systems cope and compete with the value shifts which accompany a rapid increase in economic activity? This is the classic problem of anomie pointed out by Durkheim (1947). If community institutions do not work to enhance social, political, and religious values, the boom community can be overwhelmed by the values of getting and spending which accompany accelerated economic activity.

The authors are developing a boom town simulation game around a Monopoly format, which attempts to confront these issues. Participants play by trading off community values, traditions, and social relationships for economic gain. A copy of the Boom Town game, still in the preliminary stage, may be obtained from the authors; users should be prepared to make some modifications in design.

RURBAN HIGH SCHOOL SIMULATION

As the boom community undergoes rapid change, persons in leadership positions must cope with complex organizational and political problems. More residents make more demands for more varied services. Often there is a complete turnover of persons in administrative positions (Cortese and Jones, 1977; Hennigh, 1978). The development of new leadership skills for problem solving in a boom town is the focus of the simulation Rurban High School.

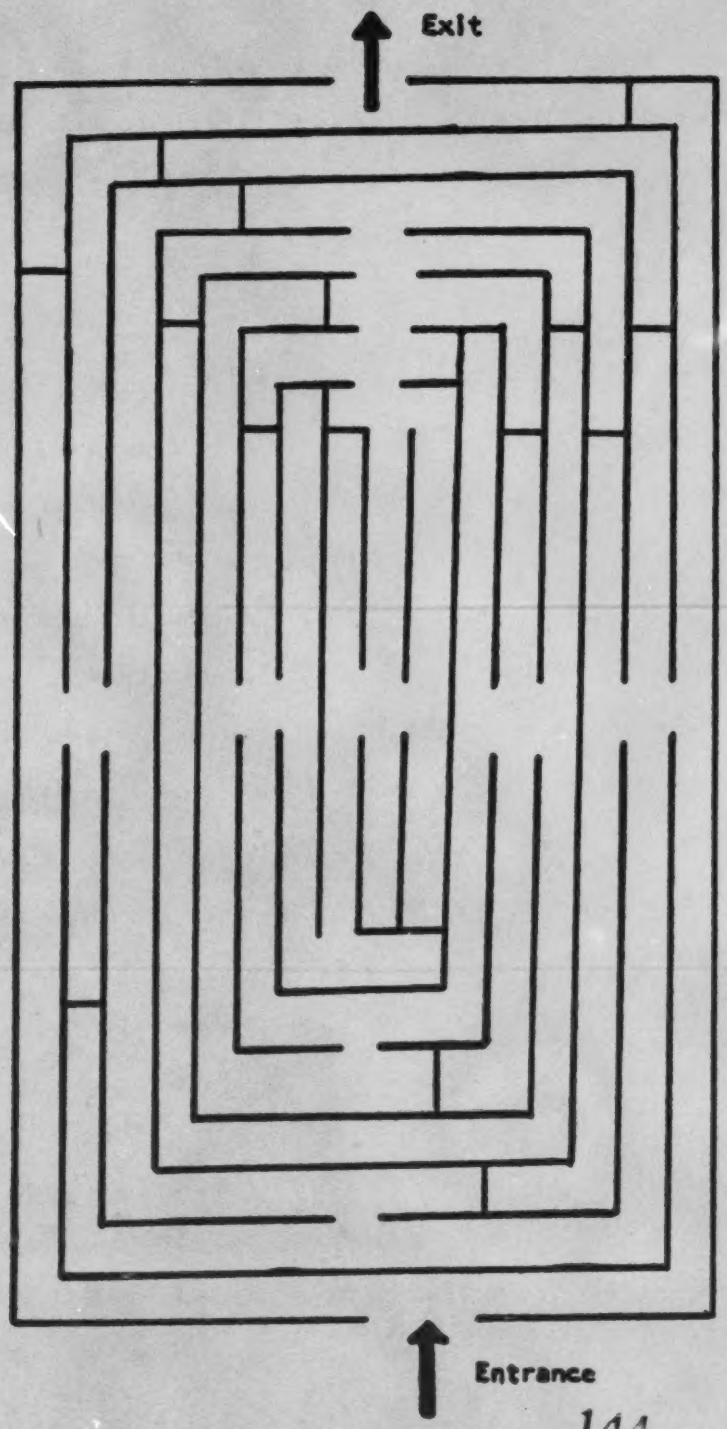
Rurban High School is designed as a plus-sum or win-win game that promotes the growth of individual and group problem-solving skills. There are no clearly identified individual winners and losers, although persons who assume planning roles do receive feedback from other players concerning their performance and have opportunities to improve their performance evaluation, or "score," as the game progresses. The overall game design, however, stimulates the formation of task groups which can identify and begin to work on alternatives for addressing problems associated with rapid growth. "Winning the game" consists of positive outcomes for all participants which may include: 1) improving one's own problem-solving skills; 2) stimulating a group problem-solving process; 3) identifying shared concerns which require community action; and 4) generating ways of responding to these shared concerns.

This simulation illustrates problems faced by adolescents in a transitional rural high school with increasing enrollment of students whose families have migrated from other areas. It has been used by social workers to develop skills for consulting with school personnel in rural communities undergoing rapid growth. A maze is constructed to simulate the complexities of planning and responding to changing needs in a boom town high school (see Figure 1). The maze can be drawn on poster board or constructed with pieces of wood.

Rurban High School should be played in two phases to be most effective. In the first phase, participants identify the problems, familiarize themselves with various people's perspectives, and explore possible solutions. This phase allows the participants to become comfortable with the technology of simulations and the props of Rurban High School. In the second phase, which should take place approximately a week after the first phase, game participants assume assigned roles and develop and evaluate solutions from these role perspectives. Roles can be assigned at the conclusion of phase one. This gives the participants time to learn their roles, mull over the problems, and develop solutions from the assigned perspectives. Examples of role assignments are mayor, council member, human services worker, principal, minority-group leader, oldtimer parent, and newcomer parent. Phase two can be repeated with new role assignments. Rurban High School can be played with ten to fifteen participants.

FIGURE 1: RURBAN HIGH SCHOOL MAZE

This maze was developed from an excercise presented by Gary Rhodes at the Annual Program Meeting, Council on Social Work Education, Phoenix, Arizona, 1977.



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Game Directions -- Phase One

1. Place the problem cards (see below) throughout the Rurban High School maze which you have constructed. Cards should be placed so that participants must encounter cards as they move through the maze. The first problem card should be placed at the entrance to the maze (see Figure 1).

2. Players develop additional problem cards based on their own experiences or ideas. These cards are also placed in the Rurban High School maze.

3. Game participants each place a move marker at the entrance to the maze. Any small available object such as a coin or paper clip can be used as a move marker. Participants are also given a set of three-by-five-inch index cards.

4. The first problem card, which has been placed at the entrance to the maze, is read aloud to all participants. After they have written a response on an index card, players select their own path through the maze. There are nine possible routes. Game participants all begin to move through the maze and encounter the problem cards. Each time a player encounters a problem card, s/he must write a solution to that problem on an index card.

5. After all the participants have gone through (and gotten out of) the Rurban High School maze and have answered all the problem cards that they have encountered, the game participants review the problem cards and share their possible solutions with one another.

6. Participants evaluate the feasibility of each of the solutions developed in response to situations encountered.

7. Participants discuss possible implementation of the solution strategies which seem to be most feasible.

8. Role assignments for phase two can be made. Participants are encouraged to gather additional information and reactions to proposed solutions prior to participating in phase two of the simulation.

Game Directions -- Phase Two

1. Place the problem cards throughout the Rurban High School maze as in phase one.

2. Game participants take one of two types of roles, assigned at the end of phase one. These roles include planners with community decision-making responsibilities (for example, principal, mayor, members of city council) or constituents (parents, students, teachers, community residents). Planners play the game by moving through the maze, writing suggested solutions to problem cards.

Constituents observe and evaluate the planners' performances. The game can be played by ten to fifteen participants. About two-thirds of the players should take planner roles.

3. Planners enter the maze at the designated starting point, using a move marker such as a coin or paper clip. They are also given a set of index cards for writing down solutions to each problem card encountered.

4. Constituents begin play by developing at least one additional problem card based on their own awareness of changes impacting boom community schools. Constituents should place these cards in the maze prior to the start of the game.

5. Constituents are given a set of score cards, used for evaluating planners' performances (see below). They are instructed to interview all planners twice and to fill out a score card after each interview. While the planners are responding to the first problem card, constituents meet together and decide who will interview each planner. During the interview, constituents should assess the effectiveness with which the planner is coping with the problems confronting boom community schools and should specifically discuss the problem card which the constituent has developed. Constituents should attempt to interview each planner twice during the game. In each interview, the constituent can discuss with the planner one problem which the planner has already encountered, or a card which the planner has not encountered if the card deals with an issue of particular concern to the constituent. In this way constituents may attempt to influence planners' responses to cards that will be encountered during the remainder of the game.

6. At the end of each interview, constituents should complete a score card and give it to the planner. At this time constituents can also decide to move a problem card which they previously have developed and placed in the maze. This card can be placed in front of any planner's move marker. The planner must write a response to this problem card before continuing through the maze. In addition, each constituent can develop one new problem card and place it anywhere in the maze during the game.

7. After all the planners have gone through the maze, responding to all problem cards that they have encountered, the game participants review the problem cards, and planners share their proposed solutions with the participants.

8. Participants evaluate the feasibility of each of the solutions developed.

9. Constituents discuss the feedback that they gave on the score cards, indicating ways in which planners were performing effectively or might improve their performance.

10. Participants discuss possible implementation of solutions which seem most feasible for dealing with real community needs.

Problem Cards

1. Energy costs have caused a cutback in the use of school buses for after-school activities.

2. Movement of new students into the community has led to severe overcrowding of schools.

3. The proposed school millage increase has been defeated. Primary opposition has come from longtime residents who oppose higher taxes to support education of newcomers' children.

4. Diverse student body has interests in new and different courses (farm/agriculture, technical/industrial, college preparatory). Can curriculum be diversified?

5. Because many people are moving into town, there are now many students who do not know each other. Rival student groups are developing, such as cowboys, dopers, jocks, and loners. How can students be brought together and a better sense of school identity developed?

6. Oldtimer teachers complain that they no longer know their students' parents. Oldtimer parents complain that they no longer know their children's teachers.

7. There are now more high school dropouts because there are now more places for them to get jobs, such as restaurants, industry, and construction.

8. The school board members (mostly oldtimers) are having difficulty responding to interests and ideas of newcomer parents, who want more representation on the school board.

9. It is difficult to get help for children who have problems because the growing community lacks supporting services for the needs of children and families, such as children's services, mental health services, and recreational facilities.

10. Because high school advisors now have more paperwork resulting from an increasing number of student transfers, the advisors now have less time for advising and counseling students.

11. There is increasing burnout among all school personnel: teachers, counselors, administrators, social workers, secretarial staff.

12. Many students move into or out of the classroom throughout the semester. Teachers do not know students' skill levels, and these may vary depending on the subject area. Often students come and go before their records arrive.

13. Fewer parents are able to attend teacher-parent conferences because of varying work schedules.

14. Increasing enrollment has resulted in larger classes, less individual attention from teachers, and students not always getting the classes they want. Students feel increasingly ignored and depersonalized.

15. You are hiring a new teacher for Rurban High School. You want someone who can deal with the difficulties of working and living in a rapid growth community. What qualities would you look for?

16. Write your own problem card.

Planner's Score Card

(To be used for evaluation by constituents)

____ Planner has developed a feasible solution to this problem.

____ Planner seems on top of situation, seeking new information, new ideas, new ways of dealing with problems and making clear decisions.

____ Planner seems to be fair and open minded. Does not appear to favor one group more than others.

____ Planner has listened attentively to my views and seems to understand my concerns.

Ratings:

++ = good, two points
+ = adequate, one point
- = inadequate, substract one point

____ Total score

NETS AND LINKS SIMULATION

An important and frequently overlooked resource for the human services worker in a rapid-growth community is the natural helping network. Rural communities may have well-developed systems of informal helping and mutual aid, although formal, professional services are relatively scarce. These informal helping patterns can be utilized in a number of ways by human service providers to extend the amount, quality, and variety of help available to persons in need.

A study conducted in a boom community by Bates, Clark, and Bertsche (1980) found that most human service providers felt that informal helpers were effective in dealing with many problems of local residents. However, human service personnel showed a limited awareness of informal helping resources within their community, did not realize the extent to which such resources were utilized, and did not make use of these resources in their work with clients.

Informal helping systems serve a number of mutual aid and support functions. Lantz, Sackett, and Eaton (1980) have suggested that the presence of strong social support systems acts as a buffer against the increased levels of stress associated with rapid growth and change. Conversely, the breakdown of social support resources can increase susceptibility to depression, illness, substance abuse, and family problems and create the need to utilize formal human services.

Specific functions of natural helping networks include emotional support, material assistance and services, reinforcement of social identity and sense of belonging, provision of new and diverse information, and access to new social contacts (Mitchell and Trickett, 1980). According to Bates, Clark, and Bertsche (1980), human service workers see these networks primarily in terms of support alone. Professionals' low awareness of the true range of functions indicates that the potential of such systems is not being tapped. Examples of potential uses for informal helping systems are given in Table 3.

TABLE 3

Informal Helping Networks: Their Potential Usefulness to Human Service Workers

Functions of Natural Helping Networks	Potential Uses of Natural Networks by Human Service Workers
Emotional Support	Link client to network of support during life crises such as divorce, death of family member.
Material Aid and Services	Develop home health care plan with client's family and neighborhood network.
Maintenance of Social Identity and Social Integration	Provide assistance in establishing a support group for parents of children with special health care needs.
Diverse Information	Provide information about formal health care services so that natural helpers can refer persons needing services. Link clients to natural helpers who can provide information about parenting skills.
Access to New Social Contacts	Link persons who have experienced a life crisis to persons who have experienced a similar crisis and coped successfully.

Human service providers can work with natural helpers in a variety of ways. The first step involves getting clients to identify members

of their social networks so that existing sources of help can be mobilized by clients themselves. If necessary, clients' networks can be expanded to include new helping resources. The human service provider can also work with the network itself. Conflicts among network members may be hindering the client's use of informal helping resources. Professionals can help to iron out such problems and to coordinate individual efforts.

Nets and Links is a simulation game designed to train human service providers to recognize, analyze, and utilize natural helping networks. Objectives of the simulation are:

1) to identify actual helping resources within the client's environment;

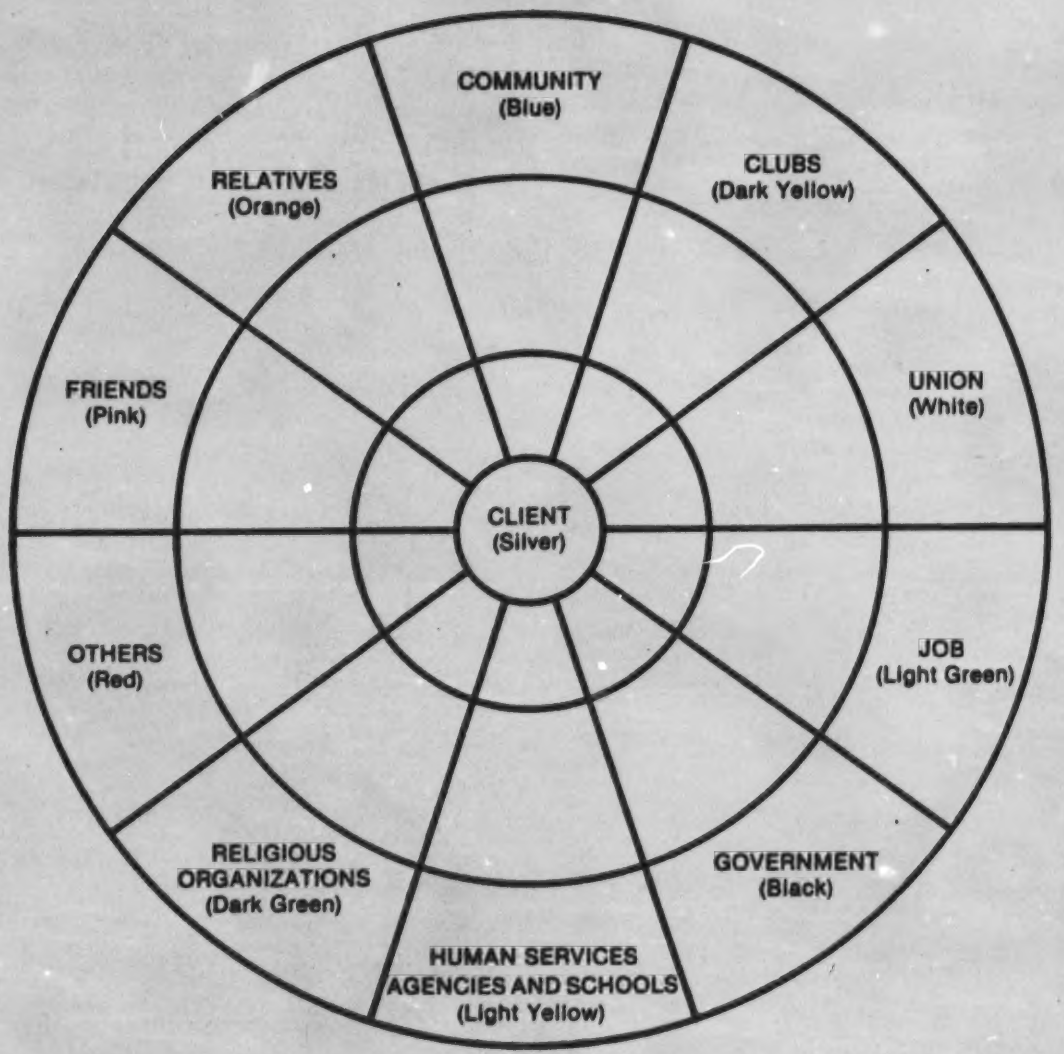
2) to discover potential helping resources and develop a plan for their utilization;

3) to pinpoint conflicts within the network which affect the functioning of the client's support system;

4) to identify areas in which greater coordination of helping resources is needed.

Participants begin by reading a case history including information about the client, the client's problems and needs, and members of the client's helping network. Next, participants construct a model of the helping network. The simulation utilizes a multicolored dart board (see Figure 2) and correspondingly-colored push pins. The dart board

FIGURE 2: NETS AND LINKS GAME BOARD



is divided into the following sectors, which represent areas of network activity:

Bull's eye: client (silver)
Section 1: relatives (orange)
Section 2: community members (blue)
Section 3: clubs (dark yellow)
Section 4: union members (white)
Section 5: job coworkers (light green)
Section 6: government agencies (black)
Section 7: human services agencies and schools (light yellow)
Section 8: religious organizations (dark green)
Section 9: others (red)
Section 10: friends (pink)

Each push pin represents an individual within one of the sectors of the helping network. Each pin is numbered and listed against the name of the person it represents on the identification sheet (see Figure 3), which is utilized during the debriefing phase of the simulation.

The dart board and push pins allow simulation participants to visualize a community helping network, to understand how it works for a specific client, to identify conflict within the network, and to involve clients themselves in analyzing the helping system. Simulation participants also analyze the relative importance of network members to the client.

Client System (Silver)

FIGURE 3: NET AND LINKS IDENTIFICATION SHEET

Relatives (Orange)	Community Members (Blue)	Friends (Pink)	Others (Red)	Religious Groups (Dark Green)
1)	1)	1)	1)	1)
2)	2)	2)	2)	2)
3)	3)	3)	3)	3)
4)	4)	4)	4)	4)
5)	5)	5)	5)	5)
6)	6)	6)	6)	6)
7)	7)	7)	7)	7)
8)	8)	8)	8)	8)
9)	9)	9)	9)	9)
10)	10)	10)	10)	10)

Client System (Silver)

FIGURE 3 (CONTINUED)

Human Services and Schools (Light Yellow)	Government (Black)	Job Coworkers (Light Green)	Union Members (White)	Club Members (Dark Yellow)
1)	1)	1)	1)	1)
2)	2)	2)	2)	2)
3)	3)	3)	3)	3)
4)	4)	4)	4)	4)
5)	5)	5)	5)	5)
6)	6)	6)	6)	6)
7)	7)	7)	7)	7)
8)	8)	8)	8)	8)
9)	9)	9)	9)	9)
10)	10)	10)	10)	10)

Game Directions

Diagram the network case example using the Nets and Links push pins and board. Board areas represent areas of interaction, and push pins represent members of the client's network.

1. Select a push pin to represent each member of the client's network colored to represent the appropriate category. If a network member belongs in several sectors of the network (for example, a friend who is also a coworker and club member), a different-colored pin should be used to represent each role. This method can help to identify problems of overuse of individual helpers.

2. Determine the distance that network members will be from one another and from the client, based upon the intensity and/or frequency of the relationship. Within each board area, place the push pins so that persons who interact frequently or intensively with the client are located closest to the bull's eye.

3. Using the identification sheet (Figure 3), write the name of each network member under the appropriate area of interaction.

4. Place the symbol NH on the identification sheet next to the network members who could be the client's natural helpers, those members of the network most willing and able to help.

5. After the push pins have been placed on the board and the identification sheet has been completed, the following questions should be discussed by the game participants.

Questions for Discussion

1. What is the distribution (number of pins in each section of the board) and balance (distance of pins from the client) of this client's network?

2. How do the network distribution and balance influence the client's use of energy, time, and resources for dealing with problems?

3. What are the areas of network underuse? What additional resources might be utilized?

4. What are the areas of network overuse? Can use of these resources be reduced?

5. What are the areas in which resources could be better coordinated?

6. Are there areas in which conflict exists among network members? How can conflict be reduced? How does conflict among network members influence the client's resources for dealing with problems? (Conflicts will not be illustrated graphically on the game board but should be noted and discussed.)

7. If you were a human service provider, how might you work with this network to assist this client?

8. Complete the following question by filling in the blank:

Anyone who plays this game can learn _____.

Case Example to be Used for Network Analysis

Beth Bolton is a twenty-nine-year-old divorced mother of two: Anita, aged seven, and Bobby, aged six. She and the children have lived in the small town of Ridgeway all of their lives. Beth's parents also live in Ridgeway. Beth's sister, Ann, and her brother, Charles, live in the nearby community of Winnsboro. Beth knows and is known by most of the community of Ridgeway and has many friends. She graduated from Ridgeway High School and throughout her life has been a member of a local church. Her minister is known as involved in helping persons who have problems.

Currently Beth is receiving Aid for Dependent Children. Her job as a waitress at the Bar B-Q provides an adequate but unstable income, as she quits or is fired periodically. Last year, when she was unemployed, Beth became extremely depressed and was voluntarily hospitalized. She is now receiving treatment at the community mental health center.

For the past year, Beth has had a live-in boyfriend, Tony. The relationship is stable, and the children regard Tony as their father. Beth's parents are angry that Beth has taken up with Tony, especially since Tony has been charged with manslaughter and is currently awaiting trial. Tony works at the Winnsboro timber mill, about twenty miles from Ridgeway. Often Beth and Tony have trouble getting to work on time, because they have only one car -- Tony's. Beth has to find a ride or drive Tony to work and use his car. This is a problem, because Tony does not trust her driving skills. (She had an automobile accident last year.) Robert, Beth's former husband, is unemployed and lives with his parents in Winnsboro. He is trying to get the children placed in his custody.

The public health nurse has visited the home and knows that Tony and Beth often do not get home from their jobs until eight p.m. and that the children are sometimes at home alone until then. Bobby is doing marginally well in school, has diabetes, and needs glasses. Anita has head lice and is failing in school. Recently the family dog ran away. Beth, as a result, is drinking, smoking more, and becoming increasingly depressed.

One of the things Beth is most proud of is the trophy her baseball team won last year. She also feels good about the union-sponsored electrical class she has begun to attend but worries because she does not have the needed tools for electrical repair work.

NEWCOMERS/OLDTIMERS SIMULATION

The influx of newcomers to a community experiencing rapid growth brings differences in life styles, socioeconomic status, and cultural values. This increase in diversity can be a source of growth or a source of community tension and conflict. Skill in coping with value diversity is developed through the Newcomers/Oldtimers Simulation.

This simulation represents conflicts between old and new residents of a changing rural community experiencing rapid growth. The exercise utilizes a role-reversal process in which participants attempt to deal with social problems from both newcomer and oldtimer perspectives.

Newcomers/Oldtimers is a game with differential outcomes for individual players. In order to win the game, each player must successfully complete activities in the areas of political awareness, economic success, and social acceptance. It is possible for every participant to win if a high degree of cooperation develops among oldtimers and newcomers during the game. If partial cooperation develops, there will be some winners and some losers. If complete polarization or bifurcation develops between oldtimers and newcomers, it will become impossible for any individual player to successfully complete all the political, economic, and social activities. Under conditions of total lack of cooperation between oldtimers and newcomers, no one will be able to win the game.

PLAYER OBJECTIVES

A participant successfully completes the game if s/he achieves the following three objectives:

1) political awareness -- player is able to identify three issues of concern in the community and for each issue player is able to state accurately the way in which the issue is perceived by both oldtimers and newcomers;

2) economic success -- player completes a "run," which consists of five economic success cards of the same color in numerical sequence -- one through five, two through six, or three through seven;

3) social acceptance -- player has his/her social acceptance card signed by the majority of players in the alternative cultural group.

Game Directions

1. Players are evenly divided into newcomers and oldtimers. The game can be played by ten to twenty participants.

2. Players form a group of newcomers and a group of oldtimers. Each group is given the appropriate set of issue cards, which are divided among group members. Newcomers are given only the set of cards representing newcomer perspectives; oldtimers are given only the set of cards representing their perspectives. Players read and discuss each issue card among themselves, familiarizing themselves with the issues of concern to their particular group. Players are also issued their social acceptance cards, which other members may decide to sign during the game, and seven color-number economic success cards, used to complete a run. Director reviews the three player objectives with participants.

3. Players are instructed to begin talking with members of the other group. Each player's task is to interview all members of the other group using the issue cards. The total interviewing process ordinarily will last thirty to forty-five minutes.

4. During each interview, the player must determine: a) the other player's perspective concerning at least one community issue; b) whether or not to sign the player's social acceptance card (see below); and c) whether to trade one or more color-number cards.

5. At the end of the interviewing period, players will identify three community issues and write down their group's initial perception, the issue as perceived by the group whom they interviewed, and whether or not they have changed their perception of the issue as a result of the interview.

6. Each player then presents the information in his/her issue write-up to the group. Each presentation is discussed by the group in terms of the accuracy with which it depicts both newcomer and oldtimer perspectives concerning issues confronting the changing rural community.

7. Finally, each player discusses his/her perception of why other group members were or were not willing to sign the social acceptance card. Game closes with discussion of cultural values of newcomers and oldtimers and of how value diversity can be managed in the changing rural community.

Issue Cards

Persons coordinating the game construct two sets of issue cards. One set contains newcomer perspectives on community issues, and one set contains oldtimer perspectives. Game coordinators may consult Table 2, page 119, for some suggested newcomer and oldtimer perspectives on a variety of issues.

Economic Success Cards

Persons coordinating the game can construct a deck of economic success cards from construction paper or different-colored index cards. For ten players, a deck of cards consists of five different colors. Each set of color cards contains fourteen cards; each card is assigned a number one through seven and the sequence is repeated. Additional sets of a different color are constructed using the same process. As the number of players increases, new sets of colored cards can be added. Basically, the cards resemble a pinochle deck containing five or more suits. The cards should be shuffled and dealt out to participants by the game director.

Rules for Trading Cards

During each interview, players must decide whether or not they want to trade cards with others. Players may not show their cards to

each other. They may ask another player for one or more cards. They may also tell a player about a card or cards which they are willing to trade. Trades do not have to be one for one. A player who needs a particular card to complete a run may offer several cards in exchange for a needed card. Players may trade cards during an interview or may trade with players whom they have previously interviewed concerning community issues. Players may not trade cards with players whom they have not interviewed.

Players may trade information as well as cards. If a player knows the location of a card needed by another player, that information may be offered as part of a trade. Players do not have to complete a trade during each interview; however, they must at least explore the possibility of trading.

When a player successfully completes a run, the cards should be given to the game director. The player will then be issued seven new cards by the game director. During the course of the game, the director may distribute one or more additional cards to individual players.

Social Acceptance Cards

Index cards can be used as social acceptance cards. The cards are signed on the basis of the following sets of rules, which are distributed to each player group.

Newcomers, sign the oldtimer's card if:

1) oldtimer feels that newcomers have something to offer to the community and seems to respect your work experience, new ideas, and the different approaches to new situations which you have gained from living in other parts of the country;

2) oldtimer is aware of boom community problems which affect all residents. S/he should seem to believe that the community can change for the better and should not say to newcomers, "This is our community. Love it or leave it";

3) oldtimer tolerates some difference in life styles and accepts people for what they are;

4) oldtimer seems willing to share some community leadership roles with newcomers and expand leadership roles to include newcomers. S/he should feel that there are many problems in the community and that all can help;

5) oldtimer has not tried to take unfair economic advantage of you (e.g., by giving false information about the location of a color-number card, or by refusing to trade cards, or by pretending not to have a card s/he does have).

Oldtimers, sign the newcomer's card if:

1) newcomer seems to respect and value your knowledge of the community. S/he should see the community as a place which has its good points as well as its problems and should not consistently downgrade the community in comparison with other places where s/he has lived;

2) newcomer seems concerned about community problems, is not just here to make money;

3) newcomer basically seems to be an honest, decent person who will not be a bad influence on the young people of the community;

4) newcomer is not a threat, will not take over community economic and political leadership but will work with other residents to solve problems in a cooperative manner;

5) newcomer has not tried to take unfair economic advantage of you (e.g., by giving false information about the location of a color-number card, by refusing to trade cards, or by pretending not to have a card s/he does have).

THE POSTINSTRUCTIONAL PHASE

Students, agency practitioners, and community residents who have participated in these simulations are given the assignment of developing an instructional simulation which can be used to deal with a problem they are encountering in their own community. Follow up sessions can be held in which game participants present and discuss the simulations which they have developed. Examples of simulations which have been developed include a game to deal with increased religious diversity and the role of churches in boom communities and a parent-child problem solving game designed to address problems of growing up and of parenting in a boom town. Thus participants are better equipped to prepare others for practice in the changing boom community.

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BEING THERE: A NURSING PROGRAM THAT INTRODUCES STUDENTS TO THE PRACTICAL PROBLEMS AND REWARDS OF OUTPATIENT RURAL MENTAL HEALTH CARE DELIVERY

by

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The health manpower shortage in rural and sparsely populated areas has been identified in the literature during recent years. This maldistribution results in limited access to health services and is a matter of concern to both public and private interests (Ozarin, Samuels, and Biedenkapp, 1978; Sedgwick, 1977). In the United States, there has been a widening of public health services to include mental health, chronic-disease detection, accident prevention, and other activities beyond communicable disease control, but this broader scope seldom applies to the small health departments in rural districts (Roemer, 1976). In particular, in eastern Washington state, mental health services as well as other health care services are located in the larger cities. These services are inadequate to meet the needs of the cities' populations much less those of the surrounding rural area (Washington State Department of Social Services, 1976).

Health care providers are least attracted to rural areas; therefore, many necessary services are not provided, and health needs go unmet. There appear to be several reasons for the unpopularity of health care careers in small communities and rural areas. These include cultural and professional isolation, limited community resources for delivering health care, environmental barriers limiting access to care for patients, and little or no educational or experiential preparation for dealing with the special problems and needs encountered in these areas (McAtie, 1978; Ozarin, Samuels, and Biedenkapp, 1978).

Nurses are apparently in an excellent position to offer services to help alleviate the problem (Mowie and Hazlett, 1975). Ray and Clark (1977, p. 32) note that

> professional nursing today emphasizes critical thinking in problem solving, judgment in decision making, proficiency in techniques of care, and actions based on a sound theoretical rationale. Nurses are called upon to assume increasing responsibility and accountability in independent and interdependent roles in a variety of settings. They utilize others as resources, serve as resources to others, and plan with others for the care of the client.

Nurses are also equipped to address client needs in a variety of dimensions -- physical, psychological, cultural, spiritual, and sociological.

This article describes how one baccalaureate nursing program responded to the mental health needs of rural eastern Washington and provided experiences to prepare nurses for work in other small communities and rural settings. Consideration is given to the identification of health needs in the area; the selection of and entry into

appropriate agencies; and the development, implementation, and evaluation of learning experiences.

BACKGROUND ON RURAL NEEDS

Few statistics are available to describe rural health care needs adequately. Approximately 25 percent of the people of the U.S. live in rural areas, and about 40 percent of our nation's poor are found in such settings (McAtie, 1978). The prevalence of heart disease, mental and nervous conditions, and arthritis and rheumatism increases with decreasing family income (U.S. National Center for Health Statistics, 1964). The health status of the poor is a multidimensional problem that includes inadequate and crowded living facilities; lack of education; and health services that are fragmented, uncoordinated, geographically inaccessible, and separated from those of middle income groups (Robertson, 1975; McAtie, 1978). The relatively large percentage of the population over sixty-five, particularly in rural areas, creates some special health care problems. The specialty care required for the elderly is less likely to be found in rural areas, and their reduced mobility makes it more difficult for them to reach the care they need (Eastern Washington Health Systems Agency, 1979). Weaver (1970) has identified high cost, poor availability, and the bureaucratic style of services as significant contributors to many health care problems. The difficulties created by these factors are magnified in rural settings.

Provision of primary care services for medically underserved populations, especially those in rural or economically depressed areas, has been identified by the U.S. Congress as the top health priority

(Eastern Washington Health Systems Agency, 1979). There are unique barriers, however, to achieving this goal. A significant problem in rural areas is the cost of transportation and outreach. Geographic factors often prevent the scattered population from fully utilizing existing programs. There is also an exaggerated stigma associated with receiving mental health services in rural areas. This negative stereotype creates an even greater than usual need for privacy and anonymity. Finally, rural inhabitants tend to have the idea that people should solve their own problems, which inhibits utilization of resources (Eastern Washington Health Systems Agency, 1979).

In 1967, the average ratio of U.S. physicians to the population they served was 1:791. The average in eastern Washington three years later was only 1:1829. The recommended ratio of registered nurses to population is 1:250. The average for 1970 in eastern Washington was 1:352. After ten years the figures were no more encouraging; in 1980, the ratios were virtually unchanged (Eastern Washington Health Systems Agency, 1979).

These statistics do not accurately reflect the ratio of health care providers to the identified rural population, since physicians and nurses tend to be congregated near population centers and statistics are gathered on a county or state basis. It can be assumed that overall the residents of eastern Washington are not receiving optimum health care and that many rural residents are not even receiving adequate health care. This conclusion has been confirmed by the Eastern Washington Health Systems Agency task force in their yearly studies since 1975. In addition to the manpower shortage, barriers

such as distance, mountains, inadequate transportation, and impassable roads during inclement weather hinder people from utilizing health care services (Eastern Washington Health Systems Agency, 1979).

THE NURSING PROGRAM

The Intercollegiate Center for Nursing Education (I.C.N.E.) is a unique consortium program providing an upper-division nursing major for approximately 365 students from four institutions of higher education, each of which offers the baccalaureate degree in nursing. These degree-granting institutions are Washington State University, Eastern Washington University, Fort Wright College, and Whitworth College. Students meet the general requirements of the school of their choice and take the lower-division prerequisite courses prior to admission to the I.C.N.E. at the beginning of their junior year. Students enter the nursing major with a diversity of backgrounds. Two of the sponsoring schools are public, state-supported institutions, and two are private colleges, one with a Presbyterian orientation, the other Roman Catholic. Inherent in the philosophy behind the cooperative endeavor of the four sponsoring educational institutions is a strong belief that a diversity of backgrounds and experiences in the student body provides richness in building a foundation for nursing practice.

Deloughery and Miggins (1973) conducted a rural needs study to identify health needs and explore opportunities for the education of baccalaureate nursing students in rural and small community areas in eastern Washington. They recommended that students supplement existing health care services in the rural areas of eastern Washington within a hundred-mile radius of Spokane to reduce the health care delivery

deficit. The I.C.N.E. faculty subsequently made a commitment to include in the nursing program preparation for practice in rural and small communities. This decision was based on two factors. First, rural and small-community agencies are prevalent in eastern Washington, and many students plan to practice in similar settings following graduation. Second, the faculty was concerned with the problem of maldistribution of health personnel and believed that student familiarity with these settings would tend to attract them back to rural areas as graduate nurses.

Sedgwick (1977, p. 30) has argued that changes need to be made in conventional curriculum and field practicum sites.

> Curricula must be expanded to include knowledge of and sensitivity to the rural non-urban people as well as research into their unique health patterns and disease processes. Hospitals and other traditional settings are inadequate field practicum sites. There is a marked tendency in rural areas to care for one's problems in ways and manners handed down from prior generations. To alter health patterns and disease processes in such areas, it is imperative that education take place in the community.

The I.C.N.E. faculty's interest in and commitment to providing health care service to residents within the hundred-mile catchment area provided the impetus for the program. It involves senior nursing students' delivering mental health services to two small communities, referred to here as "Town A" and "Town B." Town A is a small middle-class community in which most residents live within the city limits; the population of Town B is scattered across a large geographical area, and most residents are at the poverty level.

THE COMMUNITIES

Town A

Town A's catchment area of twenty-five square miles had a population of 4,504 in 1970 and a population density of 180.16 per square mile. This area has mushroomed, and over the ten-year period of 1970 to 1980 there was a 214 percent increase in population to 14,140, with a population density of 611.43 per square mile. This growth resulted from the town's becoming a bedroom community for people who worked in Spokane but preferred to live in a smaller community. The majority of the residents of Town A live within the city limits and are in the middle socioeconomic range.

Local industry is primarily small farms and logging. Town A furnishes the basic services for the area, such as fire protection, banking, grocery and department stores, an ambulance, and schools. A hospital is located in town but closes intermittently due to financial and management problems. Other health care services include a dentist, two chiropractors, a physician, and a part-time public health nurse. Mental health personnel include a psychometrician in the schools (one day per week), local ministers, and one paraprofessional counselor who works primarily with the elderly through the neighborhood center described below. All other mental health services are located in Spokane and require commuting. There are no inpatient children's or adolescent mental health services in eastern Washington.

Town B

Town B's catchment area of two hundred square miles had a population in 1970 of approximately one thousand, with a population density of 8.3 per square mile. In contrast to Town A, changes since that time have been minimal. Industry is primarily logging, Christmas treeing, and small farmsteads. The population is scattered throughout the rugged, mountainous terrain, and health services are provided by a paraprofessional outreach worker from the neighborhood center, by a part-time public health nurse, and by referrals to Spokane. Town B is considered a poverty area, where many of the residents do not have indoor plumbing, electricity, or transportation. A van from Spokane provides area residents with transportation once a week for shopping and other appointments.

Rural communities provide an ideal setting for students to put knowledge of systems and change into practice. Although the major focus of the learning experience is on psychiatric/mental health concepts and skills, it is recognized that nurses can address several dimensions of need, including physical, cultural, and spiritual. Faculty members have found that this breadth of services increases the attractiveness of the program to local agencies in which some personnel may be unfamiliar with the expanding role of nurses.

Initially, the faculty decided to work through two agencies in each of the communities as entry points into the system: the neighborhood center and the middle school. The faculty members' philosophy is that it is wise to enter new areas slowly in order to provide time for trust to build, allowing agency staff and local residents time to

become acquainted with nursing students and faculty and their roles, and increasing the likelihood of acceptance.

Jeffrey and Reeve (1978) support the need to approach rural communities slowly and outline the special issues involved. In an urban area, a new agency may appear relatively unnoticed, but in a rural area the impact is considerably more dramatic. Since the system is relatively small, there is a general shared knowledge about the attitudes and professional skills of health care providers in the area. The new professional enters the system largely ignorant of what others know about it. It is critical to establish trust, and initial contacts are instrumental in setting the basis for this trust. The mental health worker must accept that the local health practitioner is far more knowledgeable about the community and has valuable insights to provide. The approach must be one of collaborating, showing mutual respect, and utilizing each other's skills. Finally, it is appropriate to make assessments gradually because of the nature of the rural system. The pace of life is more slow and steady, personal trust supersedes issues of competence, and the new professional is an outsider.

THE NEIGHBORHOOD CENTER

The neighborhood center in Town B was established in 1967 through the Spokane Community Action Council (S.C.A.C.) to provide referral services, legal aid, coordination of health clinics, assistance with basic needs (home repairs, food, clothing), a nutrition program for the elderly, and nonmedical emergency services. In 1973, when S.C.A.C. could no longer support the the project financially, Catholic Charities of the Spokane Diocese agreed to administer the Town B neighborhood

center and continue established services. In 1975, an extension office was opened in Town A offering the same services and managed by the same director. The Town B neighborhood center is open three days a week; the Town A center is open two days a week. No services are offered at either facility on weekends.

The administrative unit for a number of organizations and services offered through Catholic Charities, including the A and B neighborhood centers, is located in the center of Spokane. Coordination between the neighborhood centers and Catholic Charities is provided by the director. The director, outreach workers, and consultants commute from Spokane, while the secretary in each neighborhood center is local. A grassroots board composed mainly of local residents provides direction for the focus and operation of each neighborhood center. The primary emphasis of the program is to serve the needs of the poor and the elderly.

Although the services of the centers are almost identical, the locations and access to services are not. In Town A, the center is located downtown, which makes it easily accessible and highly visible. In contrast, Town B's neighborhood center is in the old Grange Hall in a very sparsely populated area with the nearest house a mile away. In the winter, the road to the center is maintained, since it is along the bus route. However, the center is not very visible, nor is it on the main thoroughfare.

THE SCHOOLS

Nursing students were initially placed in the neighborhood center and middle school of each area. As the program expanded, placements were added to the elementary and high school in the B school district. The elementary school includes first through fourth grade, the middle school fifth through eighth grade, and the high school ninth through twelfth grade. The three schools in District B are clustered together near the main highway, while the middle school in District A is located centrally in town. The elementary school and high school in District A have not been utilized due to adequate placement opportunities in the other schools.

After several informal exchanges with the principals of the middle schools and the director of the neighborhood centers about the feasibility of student placements and exploration of how the I.C.N.E. and agencies could reciprocally meet each other's needs, contracts between I.C.N.E., Catholic Charities, and the school districts were formalized.

THE CONTRACT

Initially, course faculty met with agency personnel to explore and clarify expectations of agency staff, faculty, and students. The process did not differ markedly from what occurs when faculty and students enter other agencies. The major differences were the breadth of experiences available for the students, the complexity and unusualness of the client problems encountered, the paucity of resources in rural

areas, and the amount of time and energy required to overcome the view that faculty and students were "outsiders."

The main concerns of the agencies were how students would be supervised; the roles of agency personnel, students, and faculty; the competence of students and faculty; confidentiality; use of psychiatric terminology with people in the community; and development of an effective communication system. The primary concerns of faculty were the types of client problems with which students would work; confidentiality; the amount of resistance by agency staff to student learning experiences; the potential for objections from parents of middle-school children; and how students would be supported in their role by agency staff. A great deal of time was devoted to defining the nurse's role and potential contributions and convincing people that the faculty members were realistic in their expectations of students and knowledgeable about factors in rural settings such as the close-knit structure of communities with active grapevines, the necessity for independent judgment and action, and the scarcity of resources.

The following guidelines were mutually developed by faculty and agency personnel as an outcome of numerous discussions.

1) Two students were placed initially in each community for two days over an eight-week period. The number of students placed has gradually increased to sixteen as relationships have grown and trust developed.

2) Students are assigned clients in both a school and neighborhood center. Students provide counseling through the

auspices of the neighborhood center to three elderly individuals in their homes and through the school system to two children in school. In addition, they co-lead a small group in each agency. As students and faculty have been integrated into the agencies, the number of clients and complexity of problems referred to them have increased. The focus of the counseling is determined by expressed interest and/or identified need; content may include health teaching, socialization, reminiscing, crisis intervention, and problem solving. In addition, students participate in the regular tasks of the organization as needed; they may answer phones, chart, assist with programs, and recommend referrals to other agencies.

3) Specifics that occur in group and individual sessions remain confidential, but problem areas, general behavior patterns, progress, and recommendations are shared with the agency personnel in the neighborhood center or school.

4) Students are identified with the assigned agency as well as with the I.C.N.E.

5) Faculty members are responsible for supervising and evaluating students' performance through weekly conferences, papers, and observation. Weekly meetings are arranged with students, faculty, and agency staff. Weekly informal contact between faculty and staff is maintained.

6) Client referrals are provided by the agency staff and approved by faculty. The final selections are made by the student. Initial contact with parents of school children is facilitated by the principal.

7) Students make client referrals through the relevant agency.

8) Students are responsible for maintaining adequate records.

9) Students reinforce existing agency rules with their clients.

10) Students do not limit their interventions to just the psychological aspects of care, even though these are of primary concern for their experience.

Student assignments are selected to provide a broad range of experiences with clients of different ages and a diversity of problems. By making home visits, the nursing students become more cognizant of the special needs and problems of those living in a rural setting by encountering first hand the residents' isolation caused by geographic barriers and lack of transportation and mobility. Experience in individual and group sessions as well as general staff responsibilities allow students to put into practice theoretical concepts of therapeutic relationships, small-group dynamics, play therapy, crisis intervention, short-term counseling, systems collaboration, and role negotiation and clarification.

Two main factors have facilitated entry into these agencies. First, agency personnel have been concerned about their inability to fully meet the needs of rural communities due to manpower shortages and

paucity of health services. Second, faculty members have been willing to have students experience many of the same stresses as staff and local residents, for example, driving long distances to reach residents; hiking into homes when roads are impassible during inclement weather; contacting clients who have no telephone, transportation, or close neighbors; working with difficult or problem clients; and working with clients in extreme poverty, who have no indoor plumbing, no electricity, wood-burning stoves for heat and cooking, and housing structures in very poor condition.

THE STUDENT EXPERIENCES

The Schools

Nursing students begin their experiences in each school with an orientation meeting including school personnel and I.C.N.E. faculty. Principals provide a list of potential clients for individual and group counseling. Nursing students then select the children with whom they wish to work; contact the children; and explain who they are, their role, and how they believe they might be helpful. Each child is given the choice of whether or not to meet with the nursing student(s). If the situation necessitates parental involvement, the principal initiates this process.

Problems often encountered in the schools include low self-esteem; drug and alcohol abuse; teenage pregnancy; depression; behavioral problems; low academic achievement and desire to drop out; reactions to parental divorce or death in the family; child abuse; parent/child

conflicts; and communication and relationship problems. These are addressed in a variety of ways.

Role playing and discussion are used to help children who have difficulty relating to authority figures, such as parents, teachers, principals, and sometimes nursing students. Children are assisted to identify difficulties and learn some new communication skills. School personnel, and occasionally parents, have reported positive behavior changes in children who have worked with nursing students, such as increased willingness to bring up problems, less withdrawal and expression of anger, and improvement in work habits and learning.

Support groups are used for children with specific problems, such as adolescents who have difficulty living with elderly grandparents, children identified by teachers as nonparticipators, those new to the school, those who are having academic achievement problems, or those who are acting out. Children have been able to identify common difficulties and concerns and to support each other. As children have worked with the nursing students, teachers have reported increased participation in formal classes, less acting out, improved grades, less absenteeism, and more open discussion of problems. Since many students have reported problems getting to and from school after hours, transportation has been arranged to allow more participation in after-school activities.

When severe problems such as drug abuse, child abuse, depression, and alcoholism are detected, referrals are made to appropriate agencies, such as the mental health center in Spokane. Conferences are also held with parents, principals, and teachers to develop strategies

and support for assisting the children. In other situations, problems are explored jointly with the children, parents, and school personnel and resolutions found. For example, in some cases children carry many work responsibilities in the home and come to school suffering from sleep deprivation; in others, nutritional deficiencies are apparent.

Attention is also given to matters of health and hygiene. Based on the interest of a number of children, nursing students have developed options with the schools to assist children to overcome hygiene problems. The opportunity to shower at school is provided to those who have no running water at home or who must walk long distances and arrive at school overheated. Clean clothes and oral hygiene accessories may be kept in lockers. In some instances, extra clothing has been collected to supplement the wardrobes of needy students. In addition, nursing students teach several classes on topics such as sexuality, hygiene, drugs and alcohol, and mental health.

The Neighborhood Centers

At the orientation meetings in the neighborhood centers, the goals and philosophy of the agency are reviewed and the students' role delineated. The records of potential clients are presented, and nursing students are given the opportunity to meet clients accompanied by the outreach worker. Students then choose the clients with whom they wish to work, contact the clients, and develop their contracts for individual and group sessions.

The types of problems with which the students work in the neighborhood centers include depression; loneliness and isolation;

paranoia and other forms of psychosis; dependency; grieving; death and dying; body-image changes; low self-esteem; physical problems such as frostbite, diabetes, stroke, and arthritis; and learning to care for invalid family members in the home. As in the schools, the problems are approached in a variety of ways. Selected examples are presented.

Major emphasis of individual and group sessions has been directed toward decreasing isolation which adds to feelings of anxiety and suspiciousness and may be contributing to sporadic psychotic episodes. Developing a network of support and contact has been a primary focus. Nursing students make special efforts, especially in winter months, to make home visits and take groceries to people who live alone. In addition, neighbor-to-neighbor support is fostered to build relationships within the community. Group meetings focus on loneliness and how to cope with it. From these discussions, some people have made commitments to see each other once a week to go walking or simply to visit. Those with cars are reaching out to those without, to transport them to functions at the neighborhood center and local churches. A widowed Greek woman who speaks limited English has been connected, through contacts with the Greek Orthodox Church in Spokane, with people who speak Greek. Nursing students also write letters for elderly clients to their children who live out of the vicinity. Housebound clients are initially encouraged to attend activities in the company of or go have coffee with nursing students. From these beginnings, contacts are made and people start to develop relationships with others.

Conflicts between elderly parents and their adult children are frequent. Often nursing students are able to facilitate understanding

between the parties by helping them to discuss their concerns about dependency, demanding behavor, guilt, and rejection. Physical limitations coupled with the paucity of outside resources create the most difficulties. Nursing students assist those who are dependent on adult children to find additional ways to meet their needs through neighbors, churches, and neighborhood centers. Areas in which individuals can gain more independence are explored. In some instances, if options are very limited, the outreach caseworkers have increased their interventions. By such methods, family caretakers receive some relief from their responsibilities. Feelings of resentment are decreased for all parties.

Crises running the gamut from suicide threats to physical emergencies, sudden death of significant others, and financial difficulties are also frequently managed by students. Referrals to other agencies are made as needed.

The Nursing Students

Although the nursing students perform well in rural settings, all experience cultural shock to some degree. Many are challenged to evaluate their own values and attitudes. In addition, they are isolated from their peers, which interferes with their usual support systems. The rural setting is less structured than many places in which they have had previous clinical experiences, often creating increased anxiety. Concomitant with the isolation from peers and lack of structure is a greater need to utilize faculty as consultants. This is difficult at first, as often students tend to focus only on the evaluation role of the faculty in other settings. Some nursing students complain

about the extra time and money involved in extensive travel to rural areas. Although it is a good learning opportunity, students find it frustrating trying to deal with the bureaucracy and politics involved in obtaining resources for clients. There is a tendency to become immobilized at times from the frustrations of having to work through many problems repeatedly.

In spite of the above stresses, the benefits gained from rural experiences seem to far outweigh the problems encountered. Nursing students definitely gain greater competence in using their professional judgment and therapeutic skills. In addition, they are challenged to develop their skills in utilizing principles to improvise techniques due to the lack of resources and the informality of the settings. The reluctance to attach psychiatric labels to blatant pathology allows students not to sensationalize problems but rather to view them as difficulties of everyday living. Nursing students become more comfortable with authority figures and learn to collaborate with professionals and paraprofessionals in other disciplines. They have the opportunity to function more independently than is often possible in other settings and to work with clients of all ages.

It is clear that clients need to be active participants in their care, since the students are guests in the homes and schools rather than participants in a mandated treatment program. Many nursing students express pleasure and surprise that they can offer a worthwhile service where they can see and measure their impact on clients. They see that they are able to meet the course objectives, and they begin to appreciate the differences between rural and urban settings, such as

special needs, pace, differences in severity of problems encountered, and contrasts in available resources. Nursing students become adept at assessing and negotiating both professional and lay systems. They learn to identify both the official and the unofficial communication networks.

SUMMARY

The faculty of I.C.N.E. strongly believes that rural experiences not only provide unique learning opportunities for nursing students but make a contribution toward meeting health care needs of rural residents by extending available resources. The magnitude of needs and severe paucity of existing resources provide the nursing students with many challenges and rewards.

The dynamics of relationships between nursing students and clients in these rural settings are the same as in any therapeutic relationship. The severity of problems encountered and the related tolerance for deviance within the family and community are greater than originally anticipated by faculty and students. The people of these rural communities demonstrate many strengths and an essential ability to survive, often at a very high price, when compared to people with middle-class life styles. Relationships tend to be very intense, due to the isolation of clients and the frequent crises they encounter.

Overall, the result of the program is more positive than negative when evaluated by feedback from clients, staff, and students and by observed changes in behavior. During the course of the program, learning opportunities have expanded. The number of students assigned to the

two communities has grown from two to sixteen within a short period of time. The complexity of the problems referred to the nursing students has increased, and the number of clients requesting student services exceeds the program's capabilities. Attendance and involvement, including risk-taking, by clients has grown steadily, and most tend to follow through on referrals to other agencies. Staff members have even asked students to visit their own relatives in the community. Neighborhood center staff members have invited students to attend and participate in board meetings. Despite the expense in student time, money, and energy, rural experiences are requested when students specify their preferences for clinical assignments. In addition, students have chosen to continue working in these communities on an independent study basis.

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